

TO THE READER

KINDLY use this book very carefully. If the book is disfigured or marked or written on while in your possession the book will have to be replaced by a new copy or paid for. In case the book be a volume of set of which single volumes are not available the price of the whole set will be realized.

Checked

AMARSINGH

COLLEGE



Library

Checked
1976

Class No. 122-6

Book No. R 13M

Acc. No. 5197

82



Department of Criminal Science, Faculty of Law, University of Cambridge

ENGLISH STUDIES IN CRIMINAL SCIENCE, VOLUME II

EDITED BY

L. RADZINOWICZ

M.A. (GENEVA); LL.D. (CRACOW); LL.D. (ROME)

AND

J. W. C. TURNER

M.C., M.A., LL.B. (CANTAB.)

MENTAL ABNORMALITY AND CRIME

14.
com-05
Alm-02.

MENTAL ABNORMALITY AND CRIME

INTRODUCTORY ESSAYS

BY

R. N. CRAIG

W. N. EAST

R. D. GILLESPIE

E. GLOVER

D. K. HENDERSON

E. O. LEWIS

D. R. MacCALMAN

A. MacNIVEN

E. MILLER

J. D. W. PEARCE

J. R. REES

G. DE M. RUDOLF

G. M. SCOTT

PREFACE BY

PROFESSOR P. H. WINFIELD

K.C., LL.D. (CANTAB.), HON. LL.D. (HARVARD), F.B.A., J.P.

MACMILLAN AND CO., LIMITED
ST. MARTIN'S STREET, LONDON

1944

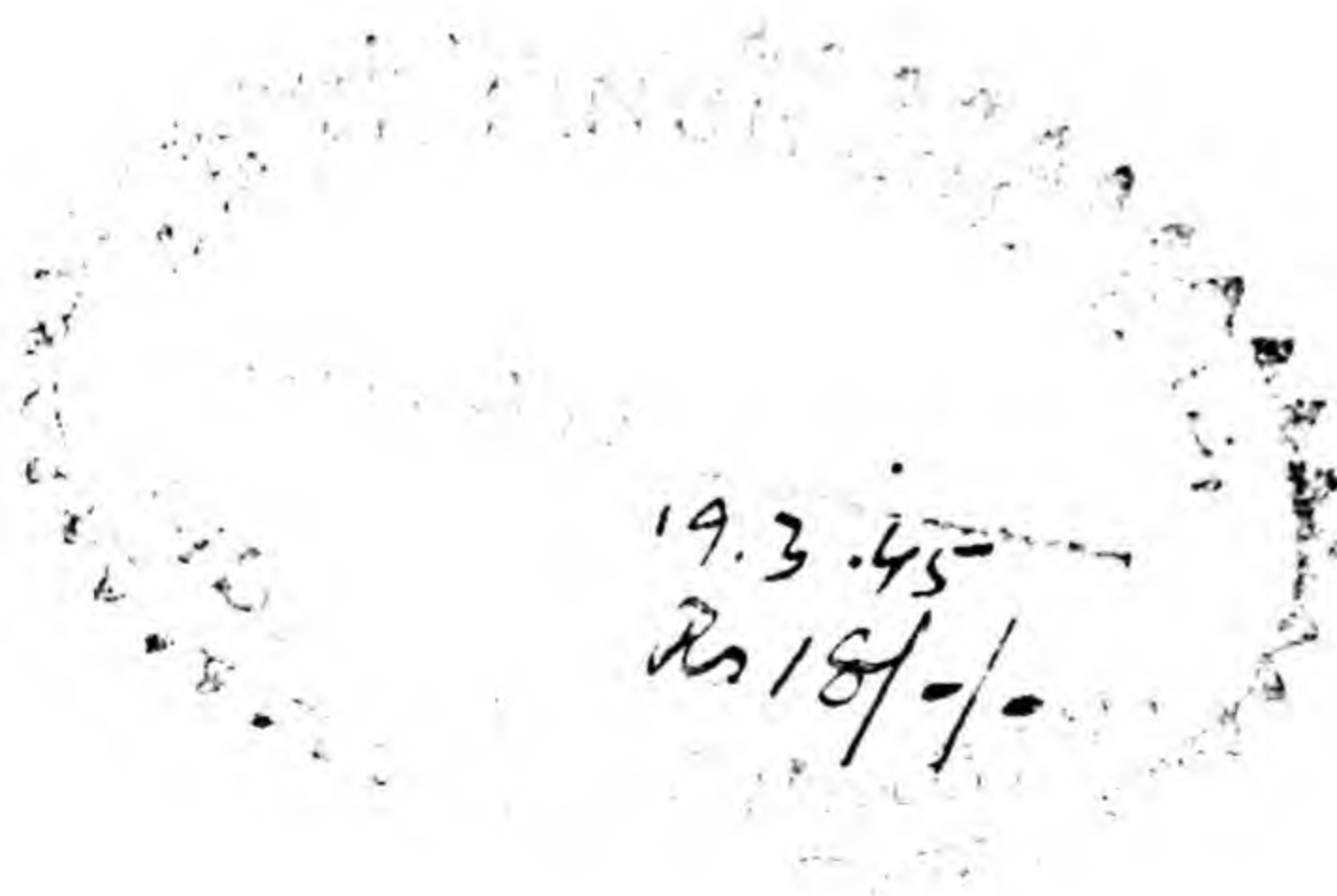
This volume is published under the auspices of the Department of Criminal Science of the Faculty of Law in the University of Cambridge. It must be understood that the Department does not necessarily agree with the views expressed by the Authors.

132.6

R 13 M

acc no 5197

COPYRIGHT



PRINTED IN GREAT BRITAIN

CONTENTS

	PAGE
PREFACE - - - - -	vii
EDITORIAL NOTE - - - - -	viii
<i>by L. Radzinowicz and J. W. C. Turner</i>	
I. MENTAL VARIATIONS AND CRIMINAL BEHAVIOUR -	I
<i>by Brig.-General J. R. Rees, M.D., M.R.C.P., Medical Director of the Tavistock Clinic, London; Consulting Psychiatrist to the Army</i>	
II. PSYCHOSES AND CRIMINAL RESPONSIBILITY - - -	9
<i>by Angus MacNiven, M.B., Ch.B., M.R.C.P.Ed., D.P.M. (Lond.); Physician Superintendent, Glasgow Royal Mental Hospital; Lecturer in Psychological Medicine, University of Glasgow; Honorary Consulting Physician in Psychiatry, Western Infirmary, Glasgow</i>	
III. PSYCHO-NEUROSIS AND CRIMINAL BEHAVIOUR - -	72
<i>by R. D. Gillespie, M.D. (Glasgow), F.R.C.P. (Lond.); D.P.M. (Lond.); Physician for Psychological Medicine, Guy's Hospital; Consulting Physician, the Cassel Hospital; Acting Air Commodore, R.A.F.V.R.</i>	
IV. MENTAL DEFICIENCY AND CRIMINAL BEHAVIOUR - -	93
<i>by E. O. Lewis, M.A. (Cantab.); D.Sc. (Lond.); M.R.C.S. (Eng.); L.R.C.P. (Lond.).</i>	
V. PSYCHOPATHIC CONSTITUTION AND CRIMINAL BEHAVIOUR	105
<i>by D. K. Henderson, M.D., F.R.C.P.E., Professor of Psychiatry, University of Edinburgh</i>	
VI. FUNCTIONAL NERVOUS DISORDERS AFTER INJURY - -	122
<i>by D. R. MacCalman, M.D., Ch.B., F.B.P.S., Crombie-Ross Lecturer in Psychopathology at Aberdeen University; Medical Officer in charge, Department of Psychological Medicine, Royal Infirmary, Aberdeen; Consultant Psychiatrist, Emergency Medical Service</i>	
VII. PHYSICAL FACTORS AND CRIMINAL BEHAVIOUR - -	131
<i>by W. Norwood East, M.D., F.R.C.P., Special Consultant to the Royal Navy; Lecturer on Crime and Insanity, Maudsley Hospital (London University); formerly H.M. Commissioner of Prisons; Director of Convict Prisons; Medical Inspector H.M. Prisons, England and Wales; Inspector of Retreats under the Inebriate Acts; Senior Medical Officer, H.M. Prison, Brixton</i>	
VIII. ALCOHOLISM AND CRIMINAL BEHAVIOUR - - -	163
<i>by G. M. Scott, M.A., B.Sc., M.B., Ch.B.</i>	

	PAGE
IX. SEXUAL OFFENDERS - - - - -	177
<i>by</i> W. Norwood East, M.D., F.R.C.P., Special Consultant to the Royal Navy; Lecturer on Crime and Insanity, Maudsley Hospital (London University); formerly H.M. Commissioner of Prisons; Director of Convict Prisons; Medical Inspector H.M. Prisons, England and Wales; Inspector of Retreats under the Inebriate Acts; Senior Medical Officer, H.M. Prison, Brixton	
X. CERTAIN ASPECTS OF JUVENILE DELINQUENCY:	
1. PHYSICAL AND MENTAL FEATURES OF THE JUVENILE DELINQUENT - - - - -	208
<i>by</i> J. D. W. Pearce, M.A., M.D., F.R.C.P.E., D.P.M.; Lieut.-Col., R.A.M.C., Medico-Psychologist, London County Council; Honorary Psychotherapist, West End Hospital for Nervous Diseases; Honorary Physician, Institute for Scientific Treatment of Delinquency; Psychotherapist, Tavistock Clinic	
2. THE SOCIAL AND FAMILIAL STUDY OF JUVENILE DELINQUENCY - - - - -	216
<i>by</i> Emanuel Miller, M.A. (Cantab.), M.R.C.P., D.P.M. (Cantab); Psychiatrist, West End Hospital for Nervous Diseases; Physician, Tavistock Clinic; Co-Director, Institute for Scientific Treatment of Delinquency; Hon. Director, East London Child Guidance Clinic; Major, R.A.M.C.	
3. THE PROBLEM OF BIRTH-ORDER AND DELINQUENCY -	227
<i>by</i> Emanuel Miller, M.A. (Cantab.), M.R.C.P., D.P.M. (Cantab); Psychiatrist, West End Hospital for Nervous Diseases; Physician, Tavistock Clinic; Co-Director, Institute for Scientific Treatment of Delinquency; Hon. Director, East London Child Guidance Clinic; Major, R.A.M.C.	
XI. REACTION TO MILITARY LIFE AND CRIMINAL BEHAVIOUR	240
<i>by</i> G. de M. Rudolf, M.R.C.P., D.P.H., D.P.M., Major, R.A.M.C., Command Psychiatrist; Psychotherapist, West End Hospital for Nervous Diseases	
XII. THE DIAGNOSIS AND TREATMENT OF DELINQUENCY (BEING A CLINICAL REPORT ON THE WORK OF THE INSTITUTE FOR THE SCIENTIFIC TREATMENT OF DELINQUENCY, DURING THE FIVE YEARS 1937-1941) - - - - -	269
<i>by</i> Edward Glover, M.D., Chairman of the Scientific Committee of the Institute and Senior Director of the Psychopathic Clinic	
XIII. REPORT ON THE WORK OF THE EXETER CHILD GUIDANCE CLINIC - - - - -	300
<i>by</i> R. N. Craig, M.D., B.S., D.P.M.	
INDEX - - - - -	308

PREFACE

As Chairman of the Department of Criminal Science in the Cambridge University Faculty of Law, I have been asked by my colleagues, Dr. Radzinowicz and Mr. Turner, to write some introductory remarks to this volume. I have decided that they shall be in the briefest terms, for I could add almost nothing of practical value to the Editorial Note of these two colleagues. I have but two points to make. First, I regard this as probably the most important collection of essays that our Department has published or is likely to publish; for all of us who have had anything to do with the administration of criminal law, even in the humblest of capacities, must have realised the vital importance of getting a correct picture of the mental equipment of the accused person, especially in all serious crimes, and by "serious" I mean crimes in which a conviction involves public moral obloquy. Secondly, I would emphasise (again from my own practical experience) the urgent necessity of making better provision for what the learned editors describe as "administrative machinery for supplying courts of law with such information concerning the personality of the offender as they will need when abnormality is suspected".

It remains only to add the deep gratitude of our Department to those who have so generously contributed the essays comprised in this volume, and to express our thanks to Messrs. Macmillan for their unfailing courtesy and skilled attention in the publication of the first five volumes of our English Studies in Criminal Science.

P. H. WINFIELD

ST. JOHN'S COLLEGE,
CAMBRIDGE

EDITORIAL NOTE

WHEN the subject of mental abnormality comes into the mind of an English jurist, he instinctively thinks first of the relation between insanity and criminal responsibility as defined by the McNaghten rules. This relation is of course a matter of great importance, but it would be a grave mistake to suppose that the case of the insane offender is the only one which need be considered. Insanity should not occupy more than one chapter in the discussion of the whole range of mental cases covered by the expression "mental variations".

The classification of mental disorders adopted by such institutions as the Royal Medical Psychological Association of Great Britain and the American Psychiatric Association shew how varied is the clinical picture of mental variations, and the heterogeneous character of their etiology. Modern psychiatric studies also reveal the surprisingly high percentage of mental cases of one kind or another in the general mass of the community. However imperfect all the evaluation of this phenomenon may be, however much the final figure may depend on the definition of mental cases which is adopted as a basis for computation, however subtle and undefinable may be the border-line cases, one fact emerges clearly from the material accumulated—mental abnormality approached from a wide point of view is a mass-phenomenon, affecting deeply the life of the whole community. To illustrate this it will suffice to refer to the authoritative works of Professor Cyril Burt and to the findings of the Mental Deficiency Committee of 1929.

The extreme complexity of the concept of mental abnormality and its vast proportions lend importance to any investigation into the relations between mental variations and crime. The number of offenders whose mental condition deviates from what may be considered as an average standard of normality is large, and these offenders are abnormal in many different ways. This association of mental abnormality and criminal activity raises important issues which bear directly on criminal law, criminal procedure, penal administration, and social policy. It seems to us that the following are the most important points: the clarification of the legal concept of *mens rea*; the classification of the different types of mental variations with a definition of each adapted for legal needs;

the selection of new kinds of sentences for the appropriate treatment of certain groups of mentally affected delinquents; the construction of administrative machinery for supplying courts of law with such information concerning the personality of the offender as they will need when abnormality is suspected; the appropriate adjustment of the prison system and of the after-care supervision; the provision of a treatment alternative to imprisonment to be applied to certain mentally affected offenders; the promotion of further research into the relation between poverty, mental variation and crime, to assist the legislature to formulate suitable measures of social prophylaxy.

Every crime, upon analysis, will be found to consist of such a result of human conduct as the law seeks to prevent. It is therefore essentially a physical event. Amongst lawyers it is usual to speak of a physical element in criminal responsibility and this means that anyone who is to be found guilty of a crime must be proved to have brought about a state of things which the law prohibits. In some of the crimes created by statute nothing further is required; the accused must be found guilty if it is established that by his act or omission he has done, or brought about, the forbidden fact. This physical element in penal liability is often termed by lawyers the *actus reus*. Apart from certain difficulties in connection with remoteness of causation, the physical element in crime has not confronted our courts with many serious problems. But although in certain crimes, as has been stated above, the *actus reus* is all that need be established against the accused person, there are others in which a heavier burden rests upon the prosecution. In these not only must the physical fact be proved, but in addition it must be established that a certain culpable state of mind must have inspired or accompanied the conduct of the prisoner. It was some hundreds of years ago that the idea insinuated itself into the Common Law of England that it was necessary to take some account of the mental processes of an accused person, a requirement which was indicated by the ancient legal maxim "*actus non facit reum nisi mens sit rea*". This Latin phrase (which may perhaps be translated "A man's act does not make him guilty unless his mind also is guilty") is crude, but it does contrast very sharply the *conduct* of the offender, *i.e.* his physical acts or omissions, with the *state of his mind* at the time, *i.e.* what he was thinking when he so acted. Of course most of the principles of our Common Law have been modified during the centuries which have elapsed since

the date of our earliest records, and the precise nature of the test of liability which the Latin maxim indicates has not always been the same throughout its history.

Our Common Law has mostly grown by a process of gradual accretion, and it is one of the features of such a development that the exact meaning and scope of a legal principle may well become difficult to determine at any particular period.

So at the present day it must be admitted that there can be some controversy as to the exact definition of the mental element in certain crimes, as is illustrated by the criticism which has been evoked by judicial dicta in such cases as Beard¹; Stringer²; Paton³; Andrews⁴; and Stone⁵.

A discussion of the history and present meaning of *mens rea* in crimes at Common Law would be far too lengthy and not of essential relevance in the present note. But it may be said that there is one basic problem which has not yet been properly attacked, and this is the question whether in investigating the prisoner's mental attitude towards his conduct the test which the law requires to be applied is *subjective* or, on the contrary, *objective*. Legal history shews us that in the earliest period of our law, before the maxim as to *mens rea* became established, the mental processes of the wrongdoer were taken into account very little, if at all. This apparent indifference to what is nowadays regarded as so important may have been largely due first to the fact that in those days the function of the law was to regulate the compensation to be paid for harm done rather than to punish the doer. Secondly, explorations into the working of a man's mind are difficult and the results conjectural, and our early courts were not properly supplied with the judicial machinery for accomplishing enquiry. Our tribunals therefore preferred to save themselves what seemed to be fruitless labour by adopting narrow rules, and held that the thoughts of man could not be investigated. Broadly speaking, a man had to pay for what he had done, and it made no difference what he may have been thinking or intending at the time. This must not now be regarded, and was probably not then regarded, as an unmoral principle, because, under the practical difficulties indicated above, it was a satisfactory working rule which would do substantial justice in the majority of cases that every harm

¹ (1919) 14 Cr. App. R. 110.

³ (1936) Session Cases 19.

⁵ (1937) 53 T.L.R. 1046.

² (1933) 24 Cr. App. R. 30.

⁴ (1937) 26 Cr. App. R. 47.

done should be compensated by the person who did it. It is clear, therefore, that at this early period, sometimes called the period of "absolute liability", there was no question of either a subjective or an objective mental test. However, ethical standards evolve, and we find that the old rules began to suffer change even in the twelfth century. Ecclesiastical laws and the penitentiaries looked primarily at the mental processes of the individual sinner and aimed at saving his soul. It was largely under ecclesiastical influence that the notion of wickedness became prominent and the idea was advanced that the wrongdoer should be *punished* for his wickedness in cases where wickedness could be established. This, however, could only be decided by reference to the man's attitude of mind. Other factors, such as the more elaborate organisation of the administrative machinery of the State accompanied the emergence of this doctrine, and in a somewhat confused way all united to emphasise the claims of a new morality in the outlook upon crime. This led to variations in liability and an increased complexity in the rules of law. A mental element in criminality was now recognised, but in assessing it a moral canon was applied, and so in mediaeval times the idea was current that liability to punishment should depend upon moral guilt. From the source whence it arose it was inevitable that when the test of moral blame made its appearance, guilt should be measured by a strictly *objective* standard. That is to say, it was assumed that there was, of course, a fixed, abstract standard of moral conduct and thought, a code of moral rules which a good man could be taught and would observe, and therefore that the question for a court of law was *not* whether the wrongdoer himself thought his conduct might be wrong, but whether it *was* right or wrong according to the accepted standard as understood by the judges. The point was, not the subjective attitude of the offender to his own behaviour, but the objective opinion of the court as to its moral turpitude. None the less, once a moral standard was admitted the operation of the prisoner's mind, whether actual or presumed, became an essential ingredient in the offence with which he was charged.

As has so often happened in our Common Law, the new principle began to operate before the older one which it seemed destined to supplant had become obsolete, and the resulting conflict in the decisions of the courts and in the arguments adduced in legal proceedings and writings tended to obscure both the old and the new. But a step had been taken which led to further progress

still. For although a moral test is necessarily an objective one, yet when it is in general application it must bring about a recognition of a subjective element of excuse in some cases where a man has caused harm unwittingly.

If a man, while acting in a way which so far as he could reasonably anticipate could not cause any harm has, none the less, owing to circumstances of which he was unaware, in fact caused such harm (for example, the death of another person), it would be difficult to hold that he is morally to blame. If, however, he is to be excused, it must be because a subjective mental test has been applied to the case. For he escapes because of what it can be proved he himself was thinking about his own conduct. His defence is that *he did not foresee* the consequences of that conduct, and that in the circumstances he cannot be blamed for not foreseeing those consequences. This, indeed, is the final point which the development of our Common Law principle of *mens rea* has reached. This development is, in fact, the resultant of several forces: to trace it would involve the exposition of a complicated and interesting chapter of legal history which would not be in place here. The point, however, which is relevant to our present purpose is that once again the phenomenon previously mentioned is to be observed. The older objective test of moral blame has not yet been entirely abandoned and it operates even at the present day for certain cases of crime. Thus it is applied when offences have been committed by children between the ages of eight and fourteen years, for in their case the prosecution in effect has to prove that the youthful delinquent "had a guilty knowledge that he was doing wrong". Again it has been judicially stated that in cases where the insanity of the accused is alleged in his defence he will, even though it be proved that his mind is diseased, none the less be punishable if he is able to know what he is doing and if he is able to foresee the consequences of his conduct, and if he is able to know that to cause those consequences is wrong "according to the standard adopted by reasonable men".¹

There has for some time past existed in this country a considerable body of opinion which is dissatisfied with the present rules of law relating to the mental element in criminal responsibility, and especially so in respect of offenders who suffer from some kind of mental abnormality. It would seem, therefore, to be of value to decide exactly what kind of mental states should be taken into

¹ *R. v. Codère* (1916) 12 Cr. App. R. 21 at p. 27 *per* Reading, L. C. J.

account by the criminal law in the assessment of criminal responsibility. This will involve a clear definition of each such mental state, framed for the use of the law. Some of these abnormal mental conditions have, of course, for a long time been so recognised in our law, the most prominent being insanity. Unfortunately the exact legal meaning of this term "insanity" has not yet been authoritatively decided.

The Report of the Committee on Insanity and Crime of 1924, presided over by Lord Justice Atkin (as he then was), the subsequent Debate in the House of Lords (May 15th, 1924) on the Criminal Responsibility (Trials) Bill, a measure based on the main recommendations of the above-mentioned Committee, the Report of the Medical Psychological Association of Great Britain and Ireland and a recommendation of the Capital Punishment Report (1930), shew most convincingly that this perplexing question is far from being solved. As can be seen from Professor Weihofen's important book on *Insanity as a defence in Criminal Law* (1933), also in the United States of America criminal law and medical jurisprudence have not yet agreed on the answer. Similar doubts exist in certain parts of the British Commonwealth of Nations; for instance, in the Criminal Code of Tasmania (1927) the concept of irresistible impulse has been adopted in order to broaden the English principle as set out in the well-known McNaghten rules.

If we turn now to the second category of mental states recognised in English law as affecting criminal responsibility, *i.e.* those defined by the Mental Deficiency Acts of 1913 and 1927, we again find cogent arguments in favour of their revision. In this connection two questions arise. First, whether the definitions of the different mental states covered by the generic term "mental deficiency" require to be reconstructed so as to widen the concept of that term. Secondly, whether the tribunals make full enough use of the various provisions of these Mental Deficiency Acts which enable them in certain cases, instead of inflicting punishment, to place the offender under guardianship, or to send him to an Institution for Mental Defectives. It seems to us that on the one hand the present legal definitions of mental deficiency require enlargement, and on the other hand that the use made by the courts of the Mental Deficiency Acts is much less than is demanded by the incidence of that type of mental abnormality among offenders brought to trial.

Another question which deserves most careful consideration is

whether there is a need to revise that part of our legislation which deals with habitual drunkards. We have particularly in mind the Act of 1898, which, amongst other things, provided for the prolonged detention of habitual drunkards guilty of offences committed under the influence of drink. We are, of course, well aware that criminal activity connected with alcoholism, as well as drunken conduct, shew in the last 40 years a considerable decrease, but there is no doubt that even to-day this group of offenders constitute a substantial proportion of all offenders brought to trial, especially among those who persistently commit crimes. The fact that except at the beginning practically no use has been made of this statute is no proof that its principle was wrong. The statute, as far as we know, has never been repealed. It remains to be seen whether at present public opinion and the tribunals would shew the same distrust of the indeterminate sentence introduced by that Act as was unquestionably shewn some forty years ago.

The crucial question, however, is whether our criminal legislation should recognise the concept of "partial" or "diminished" responsibility. The adoption of such a principle would enable the courts to take into account all those mental deviations which affect the emotional and volitional processes of human personality, and yet are not covered by the concept of Insanity or Mental Deficiency. We are particularly concerned with psychopathic and psycho-neurotic conditions of which there are a great variety and which influence so deeply the behaviour of the individual and his reaction to social environment. The doctrine of partial responsibility is known to Scots Law and the following extracts from the judgement of Lord Alness in the case of John Henry Savage, who, in May 1923, was charged with murder, will clarify its meaning:

"Formerly there were only two classes of prisoner—those who were completely responsible and those who were completely irresponsible. Our Law has now come to recognise in murder cases a third class, the class which I have described, namely those who, while they may not merit the description of being insane, are nevertheless in such a condition as to reduce the quality of the act from murder to culpable homicide. . . . It is very difficult to put it in a phrase, but it has been put in this way: that there must be aberration or weakness of mind; that there must be a state of mind which is bordering on, though not amounting to, insanity; that there must be a mind so affected that the

responsibility—in other words, the prisoner in question—must be only partially accountable for his actions.”

The recognition of partial responsibility by criminal legislation can be advocated for two reasons, and it is important to distinguish them. First, in some criminal codes in which insanity is defined in too narrow terms, the concept of partial responsibility has been introduced in order to avoid injustice. Its effect is that the offence committed is placed in a lower legal category (for instance, manslaughter instead of murder), and punishment is accordingly reduced. Thus in such circumstances it is mere expediency which has led to this recognition of the concept of partial responsibility, a recognition which, although it makes the punishment milder, does nothing to provide that such punishment is the proper treatment for a man who suffers from a particular kind of mental defect.

Partial responsibility can, however, be admitted for quite a different reason. If it be true that there are certain mental states which, without amounting to insanity within the traditional meaning of the word, give rise to or accompany criminal activity, it can be maintained that in such cases it is useless to inflict the traditional types of punishment as are provided for normal delinquents, and that the tribunals should, for example, have the power to apply an indeterminate sentence of a curative nature. The recognition of partial responsibility for such considerations as these, together with the adoption of new types of sanction would unquestionably increase the efficiency of our penal system. The fact that in such cases offenders would not be punished more leniently, but, on the contrary, would have to undergo a prolonged detention very much exceeding the term of imprisonment which would normally be applied to them, would gain the support of many who fear that such a modification of established rules would weaken criminal justice.

Criminal legislation in this country has been too often divorced from the essential findings and recommendations of modern psychiatry and medical jurisprudence. It has been too slow in recognising the existence of a vast number of delinquents who are mentally abnormal and has, in such cases, mistakenly applied traditional punishments which belong to an era when the primary consideration was the creation of punishments strictly proportionate to the gravity of each particular crime, and when the personality of the offender was hardly taken into account at all.

The effect has been repeatedly to transform the abnormal offender into a persistent one, and to leave society almost undefended against his continued criminality.

The following record of a sexual offender, extracted from the Report of the Departmental Committee on Sexual Offences against Young Persons (1926, [Cmd. 2561], p. 61) shews clearly a grave inadequacy in our present criminal legislation:

CASE B

- 14.9.06. Indecent exposure, 14 days in work-house.
- 17.9.10. Indecent exposure, 3 months' imprisonment.
- 3.8.11. Indecent exposure, 3 months' imprisonment.
- 31.10.11. Indecent exposure, 14 days' imprisonment.
- 10.7.12. Indecent exposure, 14 days' imprisonment.
- 9.8.12. Indecent exposure, 1 month or fine.
- 17.10.12. Indecent exposure, 1 month or fine.
- 17.7.13. Indecent exposure, 3 months.
- 30.6.16. Indecent exposure, 6 months and strokes with cat.
- 7.7.20. Indecent exposure, 12 months.
- 9.1.22. Indecent exposure, 12 months.
- 6.4.23. Indecent exposure, 12 months.
- 14.4.24. Indecent exposure, 12 months.

Here is an offender who, for eighteen years (1906–1924) persistently committed the same kind of offence and was continually in and out of prison. The sanction applied to him was invariably the same: imprisonment, or rather the worst kind of imprisonment—short imprisonment varying from two weeks and reaching its maximum of twelve months. There is hardly anyone who would maintain that this is the right course to be pursued in such cases. A punishment of this kind is useless from whatever point of view it is examined. It does not cure or reform the offender, it does not even intimidate him, and it does not defend society against this form of criminality.

The Committee, of course, fully realised the urgency for more enlightened measures. We read in the Report: "In cases of indecent exposure coupled with occasional offences of indecent assault, the list of previous convictions is sometimes very long; the offence has been persistently committed over very many years, and no punishment appears to have acted as a deterrent. We have had many cases brought to our notice. . . . We consider that special action is called for in cases of repeated offences such as those we

have illustrated. . . . We recommend, therefore, that consideration should be given by those in authority, to the possibilities of the prolonged detention in suitable institutions of those who repeatedly commit indecent offences against young persons.

The inadequacy of our methods of treatment of offenders who are in some way mentally affected, will be even more apparent if we bear in mind that mental abnormality is a factor not only in cases of crimes against morals or against persons, but very often also in cases of offences against property, in spite of the fact that these last are predominantly social crimes. Modern investigations into the economic and mental status of certain groups of the population have shewn that there is a close association between extreme poverty and mental subnormality. Among offenders against property, who represent more than three quarters of the whole mass of delinquents, there is also a high percentage of mentally abnormal cases. The problem becomes still more acute when one remembers how many of the offenders against property are habitual offenders. It very often happens that the traditional types of punishment, when applied to this group of offenders, are as ineffectual as they are in the cases of sexual offenders or drunkards. A committee appointed two years ago to enquire "into existing methods of dealing with persistent offenders, including habitual offenders . . ." expressed the following opinion:

"Moreover, the present system not only fails to provide adequate protection of society: it also fails to provide the treatment of which many persistent offenders stand in need. Amongst the offenders who are at present sentenced again and again to short terms of imprisonment, there are some who, if subjected to a substantial term of training, might respond to such treatment; there are others who require control for their own protection; and there are others who might be deterred from continuing their criminal careers, if the consequence to be apprehended were not a short term of imprisonment for the offence which happens to be detected, but a long term of detention for persistence in crime."

A mechanical cumulation of sentences of imprisonment of a short or medium duration, spread over years, and applied according to the gravity of the offences committed, ignoring the personality of the offender and the probability of his committing further offences is, in all such cases, of no practical use whatsoever. What is needed is not merely the introduction of new measures. The best devised of sanctions would be of no use to the courts,

they might even become a dangerous weapon in their hands, if the courts could not obtain the necessary information to decide in which cases it is advisable to make use of these new methods of treatment. Much wider and thorough information relating to the personality of the offender and to his environment should be made available, after the nature of the offence committed has been established and the guilt of the accused proved, but prior to any decision regarding the kind of punishment to be applied to him. This principle is essential in all cases where there is a reasonable suspicion that the offender suffers from some mental defect, even though this may not obviously have affected his conduct. Unfortunately, however, this has not yet become a reality in the administration of criminal justice in this country. In 1926 the Committee on Sexual Offences against Young Persons made the following recommendations: ". . . . In all cases of indecent exposure (as a fairly large proportion of these men have been found to be insane or feeble-minded) the offender should be examined as to his mental condition." And again: ". . . . In all cases of sexual offences against young persons there should be a mental examination where the offender has been previously found guilty of a sexual offence, or where the court has reason to suspect mental disease or defect either from the previous history or conduct of the accused, from his defence to the charge, or from any special circumstances in the case." And finally: ". . . . Where a mental examination is to take place . . . the Bench shall remand the offender after conviction, but before sentence, to be examined by a mental expert, and . . . the Bench should act in accordance with the result of the examination." These recommendations, put forward sixteen years ago still remain to be implemented, and far-reaching changes would have to be made in the machinery of our criminal justice in order to embody these excellent principles in the practice of the tribunals. There is much truth in the following observation made by Dr. R. M. Jackson in his book, *The Machinery of Justice in England*: "An English criminal trial properly conducted is one of the best products of our law, provided you walk out of court before the sentence is given: if you stay to the end you may find that it takes far less time and enquiry to settle a man's prospects in life than it has taken to find out whether he took a suit-case out of a parked car."

The necessity for such a reform becomes even more obvious

when we examine to what extent the above principle is still neglected in the juvenile courts. There can be no doubt that the probability of effective treatment is greater if it is applied before criminal tendencies have become criminal habits. It is, therefore, clear that a regular service carrying out thorough investigations into the personality and social circumstances of the young law-breaker should be attached to all juvenile courts and that such a system should become a permanent element in the procedure of this branch of our criminal administration.

Some work has been done in recent times towards putting this principle into practice, but this is no more than a very modest beginning. Just at the outbreak of the present war, owing largely to the generosity of the Commonwealth Fund of America and to certain other benefactors, a very important Committee, presided over by the Earl of Feversham, surveyed the Voluntary Mental Health Services of this country in order to increase their efficiency by bringing about a better co-ordination of these agencies. The Committee also investigated the possibilities of a more effective treatment of juvenile criminality, and these are the conclusions which it reached:

“Our evidence on the employment of psychiatrists and psychologists in connection with criminal courts is largely negative. Out of a hundred enquiries, seventy-five areas have no service at all. In the remainder a few have a thoroughly organised service, with the regular employment of a psychological expert in the courts, but the majority ‘occasionally refer cases in which mental deficiency is suspected.’ . . . the value of the employment of psychiatrists and psychologists in connection with criminal courts may now be regarded as proved, and it is time that the work had passed the experimental stage” (p. 145). And further on in this Report we read: “The services in juvenile courts for the scientific investigation of cases are very incomplete, except in a few larger areas. Magistrates are often unable to obtain the services of a psychiatrist. Little progress has been made, except in a few areas, in the employment of psychiatrists in criminal courts as a routine procedure, and there is a tendency on the part of magistrates to refer for special examination only those who present obvious signs of mental deficiency or disorder.” (*Ibid.*, p. 215.)

This defect in our criminal system must be admitted. No one nowadays has any doubt that the main objective which criminal policy must attack is juvenile delinquency. Three principal reasons

for this emerge from the criminal statistics and records of nearly all countries. First, it is found on the average that at least about fifty per cent. of all offenders brought before the courts are in the class of children, juveniles and young adults. Secondly, the chances of reformation are much higher in these groups than in any others. Thirdly, nearly all recidivists and habitual offenders are found to have begun their careers of crime in the years of childhood or adolescence.

An equally important requirement is a readjustment in the prison system so as to provide appropriate treatment for mentally abnormal delinquents. Many improvements have certainly been effected in this direction, but it is remarkable how long it was before public opinion and official circles seem to have appreciated that mental defects are a matter of medical concern.

As late as 1843 the New Prison Rules directed the attention of the chaplain and not that of the medical officer to "the peculiar character and state of mind of each prisoner". By 1879, however, the Committee on the Working of Penal Servitude Acts recommended that weak-minded convicts should be segregated in special prisons and should undergo a special regimen. For a very long time any differentiation in prison treatment adapted to specific groups of offenders was regarded with deep suspicion, as constituting a threat to the principle of strict legality and equality in the execution of the punishments ordered by the tribunals. Thus Sir Edmund Du Cane, Chairman of Commissioners of Prisons (1878-1894) laid down this principle in the following unequivocal terms: "A sentence of penal servitude is, in its main features, and so far as concerns the punishment, applied in exactly the same system to every person subjected to it. The previous career and character of the prisoner makes no difference in the punishment to which he is subjected. . . ."

A change of opinion as to the purpose of punishment on the one hand and progress in criminological research on the other, have slowly altered this metaphysical attitude which, seeking to find a formula of absolute justice, led to injustice, by subjecting to exactly the same treatment prisoners of widely different criminal and mental characteristics. The Gladstone Committee of 1895 urged a more thorough segregation of certain groups of prisoners suffering from mental defects, and since then special centres have been set up in some prisons and a steadily increasing understanding of the mental factor has been shown by our penal administration.

It would not be appropriate to do more here than to indicate some points which seem to be relevant in considering the treatment of the mentally abnormal prisoners. First, there should be appointed a sufficient medical staff with proper criminological and psychiatric qualifications which looks on such work as its career. Secondly, in some prisons scientific centres should be established for the purpose of observation, and, where necessary, the treatment of the more difficult cases. Thirdly, arrangements should be made for thorough and regular examinations of the personality of the prisoners, and the results should be used to construct a sound system of classification. Fourthly, whereas certain categories of these offenders can be adequately dealt with in the regular prisons, there are other categories which should be removed and placed in separate institutions expressly designed for the appropriate curative and reformatory treatment.

The wise policy of keeping as many offenders as possible out of prison altogether is equally desirable in the case of those who suffer from slight mental defects. The clauses of the Criminal Justice Bill of 1938 which give effect to this policy deserve special attention, and the hope may perhaps be expressed that Parliament will take the earliest opportunity, on the termination of hostilities, to pass these provisions into law. There is no doubt whatever that among offenders put on probation there are many who should undergo a mental treatment of one kind or another, and that if such a clause could be included in the Probation Order (and this has been so provided in the Criminal Justice Bill) it would not only make easier the work of the Probation Officer, but would also considerably increase the efficiency of the Probation System.

Penal administrators and social workers are unanimous in holding that one of the best measures for helping in the prevention of crime and in the diminution of recidivism would be the organisation of an adequate system of after-care. All those who have studied the Borstal System agree that its success is not only due to the type of the treatment which it applies, but also to the fact that the allocation of the young offender to one of the Borstal Institutions is preceded by a thorough investigation of each case by a staff specially trained who work in an institution specially set aside for this purpose. Furthermore, ever since the Borstal System has been founded the greatest importance has been attached to the building up of a system of after-care and supervision of all young

offenders released from Borstal institutions. The Borstal after-care system is closely linked up with the Borstal training. Fullest possible use should be made of these two elements when organising the after-care for offenders mentally affected.

There is, however, an additional reason for strenuously advocating the development of such a system of after-care and supervision; it is that mentally affected persons are found to form so large a percentage of what is called "the social problem group". This group has been described in the following terms in the Report of the Mental Deficiency Committee of 1929 (Part III, para. 91):

"Mental Defectives are of course found in all races and in all classes of society, among the wealthy as well as among the poor, but in any community a large number of them will be found in a restricted number of families. Let us assume that we could segregate as a separate community all the families in this country containing mental defectives of the primary amentia type. We should find that we had collected among them a most interesting social group. It would include, as everyone who has extensive practical experience of social service would readily admit, a much larger proportion of insane persons, epileptics, paupers, criminals (especially recidivists), unemployables, habitual slum dwellers, prostitutes, inebriates, and other social inefficients, than would a group of families not containing mental defectives. The overwhelming majority of the families thus collected will belong to that section of the community which we propose to term the 'social problem' or 'subnormal' group. This group comprises approximately the lowest 10 per cent in the social scale of most communities. Though the large majority of its members are not so low-grade mentally that they can be actually certified as mentally defective, it is possible that a not inconsiderable number of them might prove, if examined by expert and experienced medical practitioners, to be certifiable and subject to be placed under care and control."

This view was endorsed a few years later by the Report of the Departmental Committee on Sterilisation (Cmd. 4485, 1934, para. 75). Of course a disquisition on this so-called "social problem group" is not within the scope of our present subject, but we mention this complicated and largely unexplored phenomenon in order to show how wide a survey must be contemplated by those who study mental abnormality in connection with crime. There are, however, dangers against which it is wise to guard: while it is true, as stated in the above-mentioned Report that "deliberately to ignore mental defect is a futile policy" it must be remembered

that in many directions eugenic and social enquiries have not yet produced conclusions of sufficient certainty to warrant the taking of drastic steps in criminal legislation such, for example, as compulsory sterilisation.

These are some of the problems which the English legislator will be called upon to solve in order to shape a more effectual criminal policy concerning offenders who are below the line of mental normality. Any effort in this domain so deeply affecting the welfare of the whole community will raise many complex issues. It is here, perhaps more than in any other branch of criminal policy, that it is so difficult to strike the right balance in seeking adequately to preserve the rights of the individual while assuring the just protection of society. When aiming at a better protection of society and a more effectual treatment of the offender, we must at the same time be careful to avoid the grave danger of transforming the principle of social defence into that of social aggression. There is no doubt, however, that our present criminal policy in relation to the offender who is mentally abnormal can become much bolder without ceasing to be well balanced.

We think that an adequate consideration of these issues must be preceded by a preliminary analysis of the main types of mental variations and their relation to anti-social and criminal behaviour. This was our purpose when, nearly two years ago, we instituted the scheme which has resulted in the present volume. The first stage of our work consisted in the construction of a plan of inter-connected subjects as a framework. It seemed to us that the best results could be achieved by centralising the work of a group of distinguished members of the medical profession, who would each contribute a chapter on a particular aspect of the problem which he was known to have made the object of special research and study.

In psychiatry it is sometimes difficult or impossible to draw a sharp line of demarcation between one kind of mental disorder and another, and in a composite work such as this, a certain amount of overlapping is unavoidable. We count ourselves fortunate in having obtained the assistance of thirteen specialists who are recognised to be in the foremost rank of those who, in this country, are qualified to speak authoritatively on these subjects. We gladly acknowledge our debt to them, especially as we realise that all have been working at great pressure, either in

highly responsible posts in one or other of the forces of the Crown, or performing multifarious duties of a public character which they have undertaken in the present emergency.

The investigation of mental abnormality in crime leads into a field which is vast and complicated: our book is intended as an introduction to this, and therefore we could not offer to our authors space for a full treatment of a number of topics of which mention will be found in its pages. We hope in the future to select certain of these topics, and to subject them to the special and detailed examination which their importance merits. The view has often been expressed that the best hope for a solution of many of the problems of crime is to be found in a close collaboration between the members of the medical and legal professions. We are sure that our distinguished collaborators will consider themselves rewarded for the labours which they have so generously undertaken, if those who are concerned with penal administration find that their interest in the medical aspects of criminal behaviour is in some measure increased by the study of the present volume.

L. R.

J. W. C. T.

DEPARTMENT OF CRIMINAL SCIENCE,
FACULTY OF LAW,
UNIVERSITY OF CAMBRIDGE.

I

MENTAL VARIATIONS AND CRIMINAL BEHAVIOUR

By DR. J. R. REES

IN time of war the nation is shaken out of most of its well-worn grooves. Aggressiveness, adventure, fear and courage are all prominent in our lives; and there arise new concepts, new standards and fresh techniques for different groups and for society as a whole. There is certainly the possibility of regressing to earlier and anti-social methods of living and it is very clear that reactionary tendencies are always at work at all times like this. Great Britain, however, seems to avoid most of the worst pitfalls and in somewhat cumbrous fashion we are moving on to the formulation of war aims and planning for the post-war world. This above all can provide the drive and stimulus to achievement for the men and women of a democratic country.

The present time is therefore peculiarly appropriate for such a survey as this book attempts.

Crime is often the symptom of some specific mental or physical disease in the individual, and in every other instance it may be said to be the indication of a social dis-ease. No one in his senses would consider that measles was adequately treated by excision of the spots and in every branch of medicine it is recognised that symptomatic treatment is but a confession of our ignorance. Adequate diagnosis of the causes which underlie the symptoms must precede any effective measures towards eliminating a particular sickness or epidemic. Happily there is a growing realisation that treatment without an attempt at diagnosis, which in medicine we regard as verging on quackery, is unsound in dealing with social, as well as physical, illness. Those who administer the laws and who have to mete out treatment in the shape of punishment—be it in the nursery, the school, the Courts, or the Services—should therefore be open to charges of incompetence or malpractice just as any careless rule-of-thumb doctor might be. In facing the crime figures of the present day it is clear that society is confronted by a social problem of great magnitude which must impinge upon every aspect of our individual and corporate lives. It is remarkable that,

more obviously even than the doctors, the lawyers have in the past often appeared to lack a sense of social responsibility. It is too easy for them to stop short at the skilful administration of the letter of the law, and even of the spirit thereof, just as the doctor may follow out his textbook methods in dealing with the signs and symptoms of his patient's disease. If we are to cure the patient and prevent him infecting anyone else; if we want to learn from his particular disorder how to prevent other people falling into the same difficulties; then we must go deeper in studying the predispositions and background as well as the immediate circumstances which have led to his collapse. The well-being of society and of the public health should be our chief concern; and the prophylaxis of disease, bodily, mental and social, is what matters most. Law and medicine have fundamentally the same objective and when we who practise them can escape from our fear of each other, which so often leads to resentment and criticism, we find little divergence of opinion on basic matters and much that we can usefully discuss in the way of co-operative activity.

In this book, therefore, there is a collection of essays by doctors—psychiatrists—on various aspects of the problem of crime. From their different backgrounds and types of experience the writers of these chapters will, I hope, come to some conclusions which are agreed and valid, upon which new developments for the future can be based. Justice and social improvement are not static matters, and laws should be means to an end.

Differentiation and diagnosis of the varying types of crime is of great importance and it may therefore be of some value to make an elementary classification of the various types of delinquency as viewed from a psychiatrist's consulting room:—

1. Those cases where there is some organic or bodily disease which is relevant and not merely incidental, *e.g.* mental deficiency and encephalitis lethargica.

2. Those cases where the individual is suffering from a psychosis with a degree of unsoundness of mind sufficient to account altogether or in part for his abnormal conduct.

3. Those cases with some other psychological basis or explanation of the abnormality.

(a) Trivial delinquency; (b) Simple delinquency; (c) Reaction character traits; (d) Psychoneurotic delinquency.

All of these, if they can be diagnosed, demand different lines of treatment, and it is unsafe to assume that a particular criminal act

has always the same meaning. In fact, it may have totally different values in different individuals.

It will be wise, therefore, to amplify somewhat this very simple classification and to explain its significance.

1. *Cases with a Physical Basis.*—Quite often in the Courts physical illness of all types is advanced as the explanation for abnormal conduct or in extenuation of it. It is clear that certain acute and serious conditions, such as hypoglycaemia, *i.e.* a marked fall in the amount of blood-sugar in the body, may give rise to epileptiform seizures, loss of consciousness or less marked black-outs, which may have some important connection with a particular abnormal action. These are comparatively rare and the evidence upon which they are diagnosed is usually sufficiently convincing both to the medical man and to the Court. The most common types of disorder are those where the brain tissue itself is defective or in some way diseased.

(a) *Organic Disease.*—The after effects of concussion and brain injury, encephalitis lethargica (sleepy sickness), epilepsy, and syphilis inherited or acquired, are probably the commonest relevant disorders. Here some destruction of the actual tissue of the brain has affected the individual's capacity for self control or moral judgment. We know all too little about the exact mechanisms by which the injury and the particular difficulties are related, but it is interesting to reflect on the converse phenomena which have recently been produced in the treatment of mental disorders, unhappily still themselves unexplained. The artificial induction of an epileptiform fit by passing an electric current through the head (electric convulsion therapy) will in many patients produce almost miraculous changes of mood, from serious depression to normality, from maniacal to balanced states, or from a confused and hallucinated condition to one of rational judgment. Similarly, some recent experimental work which has been carried out has shown that by the operative destruction of certain tracts in the frontal lobes of the brain hopelessly and chronically demented persons can become markedly improved and socialised.

The diagnosis of these cases of organic disease is usually made upon physical signs which are present. Whilst one can never ignore the possibility that disease of this type has played a part in causing the delinquency, it is rarely the sole cause.

(b) *Mental Defect.*—According to statistics worked out by Professor Cyril Burt, some 26·1 per cent. of the population fall into

the group of dull and backward or into one of the groups of lower intelligence, the feeble-minded, imbeciles or idiots. It is quite clear, therefore, that this is an important group to be considered in thinking of reasons for delinquent behaviour. Intellectual backwardness, a diminished capacity to learn, is the principal complaint in what we call mental defect, but other factors have to be taken into consideration, *e.g.* the amount of education and of social adaptation and experience. The idiots and imbeciles are easily recognisable and many feeble-minded people are quite readily spotted by anyone who engages them in conversation. Intelligence tests are remarkably reliable nowadays as measures of intelligence; or perhaps it would be truer to say as methods of rating the individual's capacity to learn in relation to the average of the whole population. The defective individual is led into delinquency very easily through failure to understand what he should or should not do; by his inability to learn from experience; and by his tendency to be easily influenced by others. A defective man may show marked skill in certain directions and may have also built up a façade of normality which can be very deceptive, but intelligence tests and a competent psychiatric assessment will produce a definite finding in any of these cases.

2. *Psychosis*.—This is the medical term for a group of disorders which in their advanced stages may lead to such an unsoundness in mind that they are defined in law as insanity. Environmental and emotional factors may contribute to the production of psychosis, but there is very frequently an hereditary or constitutional basis for these conditions. It is obvious that a psychotic condition in its early stages, before it has become obvious to the layman, may be responsible for a great variety of criminal acts. The man with persecutory ideas may injure those whom he believes hostile to him; the confused or hallucinated person may commit apparently unmotivated crime. Depression, which may sometimes be regarded as psychotic and sometimes as psychoneurotic, may lead to suicide or to attacks on others.

3. *Cases with a Psychological Basis*

(a) *Trivial Delinquency*.—It may be true that for every act there is a reason but it is obvious that many aberrations of conduct are so simple and trivial that we are wise to regard them as simple lapses and not to bother about their causation. Everyone has at some time or other committed delinquent acts without any reason

save some slight absentmindedness through mental absorption, through forgetfulness, through clumsiness, or through some simple everyday indulgence. The boy who steals apples or climbs over locked gates is very likely motivated by nothing more than ordinary and quite healthy adventurous ideas, and it is easy to recognise that in the contraventions of by-laws and, for example, in many motoring offences there is nothing that deserves to be regarded as a serious crime or anti-social behaviour. These are the conditions we tend to classify as Trivial Delinquency.

(b) *Simple Delinquency*.—Here there is a definite reason for anti-social behaviour and an indication, therefore, of the line of treatment that should be taken in any particular individual. A bad home environment with lack of training and discipline may result in the absence of moral standards or in the development of standards which are certainly not those of society in general. The child brought up in the home of a successful burglar is likely to have a warped moral outlook as a result of his early association. In a different social stratum the child who grows up hearing his parents constantly relate stories of their own cleverness in fooling the Customs' Officials at Dover will also have a false idea of what constitutes honesty and an insufficient sense of social obligation. It is clear that where delinquency has a sociological explanation of this type both disciplinary and educative measures are likely to prove curative, and even a rigid and uncomprehending administration of the law will very likely do good and have much less chance of doing harm than it would in other types of cases.

(c) *Reaction Character Traits*. (Neurotic Character).—This is probably the commonest type of mental abnormality which underlies anti-social behaviour. From personal experience most of us know how we reacted to particular difficulties or situations and as a result developed a habit or character trait. The child who feels fear and is perhaps laughed at for it tends to develop a "don't care" attitude, or he shows off by doing adventurous and risky things to demonstrate his courage and manliness. The child or adult who feels inferior tends to swank or to bully. The child who feels, or is, unfairly deprived of parental affection and care may cover up his sense of need by assuming a rebellious attitude of indifference and grievance. The reaction trait, therefore, means a tendency which is developed in order to cover or mask an opposite tendency. The gangster type of boy, who is often proud to think

himself "public enemy No. 1", is therefore most often the product of early neglect with a sense of deprivation of affection. To treat his anti-social behaviour with rigid censure and punishment will tend inevitably to increase his sense of injustice. He becomes a recidivist and may quite easily be made incurable.

These reaction traits are usually formed in early childhood, and the patient has no understanding of the nature of his difficulty nor why he should be so affected. People like this are very difficult to help; often they are very unwilling to receive any sort of psychological help and resent any attempt at investigation or explanation. With careful understanding and a good environment much can be done for them. Unfortunately, punishment often makes them worse.

(d) *Psychoneurotic Delinquency*.—This constitutes quite a considerable group of the delinquents. They are people who have committed crimes as the result of some definite un-understood emotional difficulty. A distinctive feature of this type of reaction is that their conduct is quite out of keeping with their normal conduct and with their moral sense. They are genuinely shocked as a rule at their own failure and never proud of delinquency as are the people described above under the heading of Reaction Character Traits. A neurosis develops as a rule from very early emotional difficulties and is an expression of the childish attempt to deal with these difficulties, though the neurotic symptoms may not make themselves obvious until adult life. The particular anti-social act is most often an indirect method of satisfying some need that the individual fails to understand: very often, in fact, it is a symbolic method of satisfaction. Alcoholism provides a very obvious instance of this, for it is clear to even a casual observer that in most alcoholics there is an escape motive and that the compulsive drinker is trying to get away from something that he fears or is trying to get Dutch courage to remove his sense of timidity or is looking for Nirvana. Sexual perversions and many of the unusual forms of theft also result from definite neurotic difficulties. With proper help they can be understood by the patient and the situation accepted and tackled in some more satisfactory method and cure can be brought about. This group of delinquents are the most hopeful cases for psychological treatment, and they are also the sort of people who after quite simple explanation will accept the fact that punishment may be necessary "*pour decourager les autres*": though it will not do them any good it will

not harm them, and if treatment is available they will come for it when they have finished their sentence.

This is a bird's eye view and a general outline of the field, we have to explore. There are many complicated problems in front of us as psychiatrists and lawyers and there are very few easy solutions. All of us, and certainly those who have to deal at first hand with offenders, whether in the Clinic, on the Bench or elsewhere, will make a better approach to our work if we can divest ourselves of any superior aloofness which allows us to look down on the delinquent. Unless our memories are very poor (and very respectable) we recognise that we ourselves have committed anti-social and delinquent acts of nearly every kind at some time—generally undetected. There is no fundamental difference between the delinquent and the normal man save that the former has as a rule had greater difficulties and less opportunity than we who have to treat or judge him. Our attitude to the delinquent should be that of hating the thing he has done but without hating him as a man. With this in our minds and with a systematic effort to study the human being and not merely what he has done, we shall certainly have contributions to make to the solution of the problem of crime.

Dr. William Healy of Boston has in the past described how, soon after he started his first Clinic for Juvenile Delinquents in Chicago, a Judge from another State came and spent part of his vacation watching the work of the Clinic. After some weeks, when he was about to leave, he said impressively: "Dr. Healy, I have sat for twenty years on the Bench giving treatment and I never knew how to diagnose." If my memory is correct, he instituted straight away in connection with his Court a Department of Diagnosis.

II

PSYCHOSES AND CRIMINAL RESPONSIBILITY

By DR. ANGUS MACNIVEN

THE psychoses are those forms of mental illness in which the most profound disturbance of the personality occurs. The degree of disturbance varies within wide limits, and is dependent upon the type of psychosis and its degree of severity.

The personality changes which characterise the more severe psychotic illnesses result in changes in the patient's behaviour, which affect his relations with his external environment, and it is this disturbed relationship between the patient and external reality which is the chief distinguishing feature between well marked psychotic illness and the milder forms of mental illness, the neuroses and the psychoses, in which the patient's relations with his environment are only very slightly disturbed.

The symptoms of psychotic disorders do not differ qualitatively from the symptoms occurring in the minor forms of mental illness, the neuroses. Indeed, one can go further and say that psychotic symptoms are, in many instances, a distortion and exaggeration of mental processes which occur in the so-called normal mind.

The psychoses may be divided into two groups; one group comprising these conditions in which up till now no definite physical causative factor has been found: and the other comprising types of illness in which the mental symptoms arise from physical causes.

A typical example of the first group is the Manic-depressive psychosis, and General Paralysis of the Insane is an example of the second.

Our knowledge of the causation of the first group, the so-called functional psychoses, is still incomplete, and this lack of knowledge of specific causative factors makes it impossible to base a classification of the functional psychoses on a basis of etiology. The classification used is therefore still mainly based on symptomatology.

The types of mental illness we are discussing do not occur as clear-cut entities. The conditions are usually not present in pure culture, for in many cases, the clinical features are not typical of

one particular type, but show characteristics of several different reaction forms. This is not surprising if we accept the view that an attack of mental illness represents an attempt by the patient to deal with psychic difficulties, and that the means used in meeting these difficulties will depend upon the pattern of the patient's mind, and that this pattern may enable the patient to make use of various mental mechanisms, some characteristic of one clinical entity, some of another.

Thus, a case in which the general picture suggests a diagnosis of manic-depressive psychosis may present schizophrenic features, and a condition which appears to be predominantly schizophrenic may have symptoms which are suggestive of the manic-depressive psychosis.

It is this lack of specificity in the symptomatology of mental disease that affords a partial explanation of the divergence of opinions sometimes expressed by medical men in evidence in court. The fact that one psychiatrist expresses the opinion that the patient is suffering from one form of mental disease, and his colleague uses a different diagnostic label, does not signify that one of them is in error. It is quite probable that as far as their essential understanding of the case is concerned, they are in agreement. It is only their terminology that is different.

The question of a specific diagnosis is seldom of importance in medico-legal cases, although there are certain instances in which the points at issue may depend upon an exact diagnosis, as, for instance, where a person has committed a criminal act in what appears to be a state of altered consciousness, and it is essential to decide whether he is an epileptic.

THE MANIC-DEPRESSIVE PSYCHOSIS.

This is one of the commonest forms of mental illness. The condition varies greatly in its intensity. In some cases the symptoms are so mild that the condition is not recognised as a mental illness, and many mild attacks of this psychosis masquerade under such terms as "nervous breakdown" and "neurasthenia".

In its typical form, this psychosis is characterised by attacks of depression with inactivity, or by attacks of mental exaltation with over activity. To the former condition, the term "depression" or "melancholia" is applied: the latter condition is described as "mania". In the interval between the attacks, the patient seems

to be in a normal state of mind although obsessional symptoms are sometimes present. The type of cycle which occurs varies in each individual patient: sometimes only attacks of depression occurring, sometimes only attacks of mania. In other cases attacks of mania alternate with attacks of depression.

The exact cause of the condition is unknown, but the most important etiological factor is hereditary predisposition which is present in eighty per cent. of cases. An attack may be precipitated in a predisposed individual by any mental or physical strain. Common precipitating factors are: bereavement, financial loss, or any other form of domestic or business worry.

Melancholia.—The symptoms of this condition are mental depression and retardation of mental and bodily activity. The patient's clarity of mind is preserved. The memory is not affected, and the intellectual functions are unimpaired. In mild cases the social behaviour is not usually affected, and even in severe states of depression the patient may appear superficially a normal person.

A typical case of melancholia presents a characteristic appearance. The patient looks older than his years. His expression is one of dejection and despair. He moves slowly and with extreme effort. His conversation is slowed. He expresses himself as shortly as possible, sometimes in monosyllables. His emotional state is one of extreme misery. The feelings of guilt and inferiority are rarely absent, even in mild cases. In well marked depression, these occupy the forefront of the clinical picture, and the patient then expresses the delusions of sin and unworthiness, which are such characteristic symptoms of this type of mental illness. He asserts that he has committed grievous sins, that he has brought ruin upon himself and his family, and that he merits the most drastic punishments for his misdeeds. He cannot entertain any hope of his recovery; indeed, he usually resents any suggestion that he will recover. He regards his illness as a just punishment upon him for his sins. His present state, he believes, is only a trivial misfortune to the dreadful punishment he will endure in the future.

Suicidal thoughts and impulses are usually present, even in mild cases, and are invariably present in the more serious forms of the illness, and unless suitable precautions are taken, the patient will attempt to take his own life.

In states of extreme depression, there may be almost complete arrest of the patient's normal activities. He may be mute. He is

unable to do anything for himself and he requires to be fed and looked after like a child.

Mania.—This condition is in many ways the antithesis of melancholia. The mood of depression is replaced by one of elation, and this is accompanied by extreme over-activity. The condition varies greatly in intensity. In its mildest form, termed hypomania, there is a feeling of increased wellbeing, with a greatly increased interest in external affairs. The patient has the feeling of increased self-importance, he is over-confident, and he has an exalted idea of his own capabilities. He is over-talkative, interfering, domineering, and sometimes aggressive. His judgment is warped by his elated emotional state, so that his conduct is apt to be embarrassing and indiscreet.

In a fully developed maniacal state, the patient shows extreme over-activity. He is rarely still, but the direction of his activities is constantly changing so that very little is accomplished. He talks with extreme rapidity, and sometimes the stream of thought is so rapid that his conversation seems disjointed and almost incoherent. A close study of it, however, will show that there is some association between each of the ideas expressed.

His mood is one of extreme elation which is shown by joyous singing, loud laughter, joking, punning and rhyming. The mood is very changeable, and a happy amiable state quickly gives place to one of anger in which the patient becomes threatening, aggressive, and destructive. Except in states of extreme excitement, the mind is not confused. The patient is acutely aware of his surroundings, and his intellectual processes are quick and active. The general excitement and the inability to concentrate, however, prevents any constructive thought or activity.

The manic-depressive psychosis is a benign form of mental illness. In both mania and melancholia, recovery invariably occurs in young persons. There is, however, a tendency for attacks to recur throughout life, and as the patient gets older, the attacks tend to last longer, and recovery is less complete. When recovery does occur, it is usually complete, and the patient's working efficiency and his social adaptability are not in any way impaired. Even when complete recovery does not occur, the illness does not lead to the dementia which is a characteristic symptom of the chronic phase of other forms of mental illness. The average duration of the individual attacks varies from three to twelve months. Many cases last eighteen months or two years, and

recovery has been known to occur in melancholia after several years.

A variety of infringements of the law, varying in gravity from simple breach of the peace, to murder, may occur as symptoms of the manic-depressive psychoses. In fully developed cases of mania, violence and destructiveness are common symptoms, but the patient's aberration is so obvious that in most cases he is placed under supervision before he can do serious harm, so that it is rare for a maniacal patient to commit a serious criminal offence, although offences of a minor character are very common.

In hypomania the position is different, and the illness may be present for a considerable time before it is detected. The exaltation of mood, the over confidence and the lack of self criticism—which are characteristic symptoms of hypomania—often lead to irregularities of conduct, such as wild extravagances, over-indulgence in alcohol, practical joking, sexual offences (usually not of a very serious type), and sometimes insulting and aggressive behaviour, occasionally accompanied by violence. The fact that the patient's clarity of mind is preserved, that his behaviour may only represent an exaggeration of his normal character traits, often results in the true nature of his condition being unrecognised, so that there is a risk that when a contravention of the law occurs, his offence is not regarded as a symptom of a psychotic illness, but as a manifestation of moral depravity or maliciousness.

The following are instances of the type of behaviour which occurs fairly frequently in mania:

A young man was charged with a breach of the peace by recklessly discharging a pistol at a ticket collector in a railway station.

He had been in the habit of travelling to business every morning by a suburban train. As a rule, the ticket collector did not ask him to show his season ticket, but on the morning on which the offence was committed, the ticket was demanded. The patient refused to comply with the ticket collector's request, and when the latter insisted, the patient flew into a rage and in a loud imperious voice demanded how the ticket collector dared ask a gentleman of his standing for his ticket when he knew quite well that he had a season ticket. When the ticket collector persisted in his demand for the ticket, the patient produced what afterwards was discovered to be a toy pistol which made a loud explosion when it was fired, and discharged it in the direction of the railway official, who, thinking that his life was in danger, fled down the platform.

When examined by a psychiatrist, the patient was over-talkative

and exalted. He related with great pride and satisfaction the trick he had played upon the ticket collector, and also told of other practical jokes of a similar nature which he had recently carried out. For instance, on one occasion he told how he had thrown a bag of flour at a friend (who was dressed up to go to a wedding) while they were both travelling in the same railway compartment.

The patient was clear in his mind. He had no delusions, and his memory and his intellectual functions were not in any way impaired. It was quite clear, however, that his behaviour was greatly influenced by his exalted mood; that his offence was the direct outcome of mental illness.

A man of 66 years who was normally a quiet, somewhat shy, sensitive person, was found by the police in the back garden of his house in a state of partial undress.

On hearing from his wife of his recent behaviour, the police were satisfied that he was suffering from a serious mental illness, and they assisted his wife in making arrangements for the patient's admission to a mental hospital.

His family history showed a marked predisposition to mental illness of the manic-depressive type. His sister had been a patient in a mental hospital on several occasions.

The patient himself had, at one time, been a very successful business man who had amassed a considerable fortune, but owing to unwise speculation, his means had become greatly reduced.

His history showed that he was subject to recurrent attacks of manic-depressive psychosis. After three attacks of depression, he developed his first attack of mania when he was 51 years. He became very excited. He was over talkative, irritable and inclined to shout at people. His friends and business associates realised that he was in an abnormal mental state, but his symptoms were not of sufficient severity to make it necessary for him to be placed under care. This attack of mania was succeeded by a sharp depression, in which the patient was dull, lacking in initiative and unable to attend to his business. He decided to retire. After his retirement he began speculating on the stock exchange, with unhappy results, for he lost most of his money. This financial loss precipitated another period of excitement. The attack of excitement which was responsible for the episode already described, was preceded by a period of mild depression.

A week before his admission to the hospital, he became over-talkative and excited. He had difficulty in concentrating, and he was constantly giving contradictory orders to his wife and to the maid. He remained out late at night, and just before his admission to the hospital he came home at midnight and behaved in a very erotic way towards his wife's sister who was in the house. His conduct was so uncon-

trolled that his wife locked herself in her room. The patient stood for two hours outside muttering imprecations. He then went into the garden and undressed himself and exposed himself to some of the neighbours.

After three months' residence in hospital during which he showed typical symptoms of mania, he recovered, and was discharged.

Alcoholic excess is not an uncommon symptom of the manic-depressive psychoses, particularly of mania, and this leads to a further loss of self control and a blunting of the finer moral sentiments.

In the states of intense excitement which characterise acute mania, the patient may commit a serious assault on anyone who attempts to interfere with him, but, as a rule, he is easily distracted from his purpose, and his violence is often ill directed, so that serious harm rarely occurs.

In melancholia, on the other hand, although generally speaking the patient's conduct is socially correct, very serious offences are not infrequent. Melancholia is probably the most common cause of suicide and attempted suicide. Even in those cases where alcoholism seems to be the immediate cause of the suicidal attempt, it is probably the manic-depressive factor in the patient's personality that is the fundamental cause of his suicidal tendencies.

The methods of self destruction selected by the patient depend partly upon chance, and are partly the result of unconscious motives which determine the choice of method. That unconscious motivation does play a part in the method selected, is suggested by the fact that frequently the patient chooses a painful method, when one causing very much less suffering is available.

A suicidal attempt may be an impulsive act, or it may be the result of deliberate planning.

The desire to commit suicide is always dormant in the mind of the melancholic, although the thought of suicide may not always be present in his consciousness. Frequently the attempt is precipitated by some trivial exacerbation of his worries, or by some petty frustration.

A woman of 45 years of age, suffering from involutional melancholia, was looking out of the window of her room in a nursing home, when she saw the Matron, to whom she was greatly attached, leaving for a day's outing. The patient instantly threw herself out of the window, and in so doing sustained serious injuries.

She afterwards explained that in her state of misery she felt so

dependent upon the comforting presence of the Matron that when she saw her leave, she felt she was being abandoned, and in her despair, she could not refrain from attempting to destroy herself.

A distinguished professional man was recovering from an attack of depression in a private nursing home. He seemed so much improved that he was at liberty to go about the grounds freely. A friend had arranged to take him to a rugby football match (a game which the patient played with great skill in his younger days and one in which he was still greatly interested). His friend was unable to keep the appointment, and the disappointment was sufficient to reanimate the patient's suicidal tendencies, and he made an attempt on his life, which unfortunately succeeded.

A murder, or attempted murder, of persons whom the patient believes are involved with him in the disasters which he believes he has brought upon himself, is a fairly common occurrence in melancholia.

A man in a state of depression, believing that he is financially ruined and that his family will end in the workhouse, attempts, by their destruction, to save them from misery and disgrace.

A woman believing that she has infected her children with some incurable disease or that they are to share the torture and punishment which she believes is in store for herself, may feel that it is her duty to destroy them.

A married woman of 33 years of age was admitted as a voluntary patient to a mental hospital after she had administered lysol to her two children and then attempted suicide herself. One child died of the poisoning, but the other survived.

The history showed that her symptoms of mental illness dated back five years, when, after the birth of her first child she began to experience feelings of profound depression accompanied by a strong impulse to take her own life.

These feelings of depression continued, and during her child's first few months of life she began to experience strong impulses to destroy the child. She spoke to her husband and to her doctor about these alarming symptoms, but neither of them took the matter seriously. The destructive impulses towards the child continued while he was being breast fed, but later, when a change was made from breast feeding to bottle feeding, the mother's destructive impulses disappeared and her depression became less profound.

She remained comparatively free from symptoms until the later months of her pregnancy with her second child when she experienced impulses to destroy the unborn child. After the child's birth these

impulses continued with growing intensity. The patient was greatly distressed about her symptoms. She lost her appetite, and her sleep became disturbed by horrible dreams. She became more and more depressed until one morning while in a state of profound depression the impulse to destroy herself and the children became very intense and she acted upon it. She administered lysol to the two children and then to herself. One child died; the other survived. The patient herself only suffered mild indisposition as the result of the poisoning.

She was admitted to a mental hospital as a voluntary patient. On her admission she was clear in her mind and she was able to give a good account of everything that had occurred. She described the gradual development of her illness and its symptoms. She said she knew of no reason for her depression. She was happily married. She loved her children deeply. She had never experienced any serious domestic or financial worry. She expressed remorse at what she had done. At times she was apprehensive, saying that something terrible was going to happen to her. She thought that she would never recover her sanity. At times she showed great distress, while at other times she seemed bright and cheerful, so that she was able to converse with animation and to take a keen interest in the activities of the ward in which she was a patient.

On the suggestion of the Crown's legal advisers the patient was certified, but she was allowed to remain in the hospital to which she had come voluntarily.

At a later date she appeared before the Sheriff and was found unfit to plead, and allowed to return to the hospital.

Her condition gradually improved, and at the end of six months she seemed to be recovered from her illness. The Crown authorities were notified of the improvement in her condition and they appointed a Mental Specialist to examine her. His report supported that of the Medical Superintendent of the institution in which the patient was under treatment, that she had recovered, and the patient was discharged.

As a rule, when a person suffering from melancholia commits violence upon someone else, the conscious motive is an altruistic one; as, for instance, when a father kills his family under the belief that the future holds nothing but misery and disaster for them.

In the case under discussion, however, the patient was the victim of a blind, unreasoning impulse to destroy her children, and she could never at any time in her illness explain her motive for her action.

Impulses of an aggressive character which the patient is unable to explain, sometimes occur as symptoms of the obsessional neu-

roses, but in these cases, the impulses are very rarely acted upon.

INVOLUTIONAL MELANCHOLIA

Depressions occurring in late middle life and in the pre-senile period have certain characteristics which distinguish them from the depressive phase of the manic-depressive psychoses, so that this type of illness, which is usually designated involutional melancholia, is regarded by many psychiatrists as a distinct clinical entity.

The psychomotor retardation which is such a well marked symptom in the manic-depressive depression, is absent in involutional melancholia; and this condition is characterised by intense anxiety and apprehension, with painful agitation and restlessness. The patient is usually preoccupied with ideas of sin and unworthiness, and hypochondriacal delusions and delusions of poverty are usually prominent symptoms. The anxiety is frequently intense, and it is not uncommon for patients to call out aloud in their distress. States of stupor sometimes occur.

The illness varies greatly in intensity, and simple states of anxiety merge imperceptibly into this type of melancholia.

In the more severe cases, suicidal impulses are present, and the absence of psychomotor retardation makes the risk of suicide even greater than it is in the manic-depressive type of depression. The most extreme forms of self aggression are sometimes shown in this type of illness, and it is not uncommon for patients to inflict severe mutilations upon themselves.

Even in the most severe forms of the illness, the patient's clarity of mind is retained. Memory and intellectual functions are not in any way affected, and patients are often able to discuss their own symptoms and their actions with some degree of objectivity.

Self-condemnation may exist simultaneously with aggressive tendencies, and irritability and outbursts of anger, in which the patient behaves in a spiteful and vindictive way, occur. Although serious aggressive acts are not common they may occur as is shown by the following case:

A woman of 45 suffered from a typical involutional melancholia from which after nine months' treatment in a mental hospital she appeared to make a good recovery. She only remained well for a few months, then her symptoms returned. She became depressed and

restless. She lost interest in her household duties and in all other outside activities.

One morning while the patient's sister (who had been nursing her) was kneeling in front of the hearth, the patient made a violent attack upon her with a wooden mallet which she had taken from an out-house, and inflicted severe injuries upon her head. The assault seemed to be a determined one, and might have led to very serious and even fatal results.

The incident led to the patient's immediate removal to a mental hospital.

On admission she was in a state of great agitation. She spoke in a low, anxious voice, in disconnected sentences. She expressed feelings of self-depreciation, saying that it was not right that she should be in a private ward, and that she could not afford to pay for it. She expressed remorse for her attack upon her sister, saying in a low voice, "You ought to call the police. I should be in gaol. I hit my sister with a mallet. Why should I have done that when she was doing all she could for me? It must have been a case of awful spite against her."

She said that for a long time she had thought of committing suicide. She was quite clear in her mind, and her memory and intellectual functions were unimpaired.

No legal proceedings followed the assault in this case. The patient died of pneumonia while she was in hospital.

In a small number of cases there seems to be an increase in sexual desire which sometimes takes a perverse form. These symptoms are not very common, but when they do occur, they may result in a contravention of the law.

SCHIZOPHRENIA

The term schizophrenia has now generally replaced the older term of dementia praecox.

According to Henderson and Gillespie: "Schizophrenia, in its typical form, consists in a slow, steady deterioration of the entire personality, usually showing itself at the period of adolescence. It involves principally the affective life, and expresses itself in disorders of feeling, conduct, and of thought, and in an increasing withdrawal of interest from the environment."

The cause of the condition is unknown. Hereditary predisposition is a factor in the causation, but in a considerable number of cases, evidence of hereditary predisposition is absent. Many theories have been put forward to explain the condition, but none

of these have won universal acceptance. Degenerative changes in the brain have been described by some workers, but many psychiatrists believe that schizophrenia is not characterised by any specific pathological changes in the central nervous system.

The illness is a very serious one. In the majority of cases recovery does not occur, and many of the cases end in a state of profound dementia. The morbid process may, however, be arrested at any stage in its development, and there are a certain number of cases in which very complete remissions occur. A certain type of personality appears to be associated with this form of illness. In childhood many of these patients show evidence of maladaptation. They are shy, reticent, sensitive individuals who have difficulty in making social contacts. They are easily rebuffed, and their general attitude to life is lacking in healthy aggression. They tend to withdraw into themselves and seek the satisfaction, which their inability to participate in normal healthy activities deny them, in day dreams and fantasies. Others react by an attitude of detachment. Many are lacking in emotional warmth. They are stilted and uneasy in their contacts with other people, or they adapt an attitude of cold cynicism to life.

In dealing with his internal conflicts, the schizophrenic makes use of a greater variety of unconscious defence mechanism than any other type of mental illness, but the mechanisms are used erratically and lack systematisation, so that a great variety of symptoms characterise the illness, and fragmentation of the personality occurs, so that the patient, in his conduct, seems to act under uncontrolled impulses.

Perhaps nothing is more characteristic of the schizophrenic's attitude to life and to himself than a state of vague dis-satisfaction which nothing appears to relieve. One gets the impression that he is constantly seeking some goal which he never attains.

Episodes occur in which the mental mechanisms characteristic of other types of mental illness appear; for instance, states of depression with acute feelings of guilt, suggest melancholia. In other cases the projection mechanisms characteristic of paranoia are prominent features in the clinical picture.

The illness is usually insidious in its onset. Sometimes it is unnoticed until attention is called to the patient's state by some abnormal act, such as attempted suicide, or an act of violence against other people. Although as a rule the illness is of slow development, at times the onset takes the form of a sudden acute

acc no 5197

episode. These acute states often occur when the patient is faced with some major decision involving his emotional life, such as, for instance, the death of a relative, a love affair, or an impending marriage.

The four varieties of the condition: the simple, the hebephrenic, the paranoid and the katatonic are usually described. It is not always possible to allocate a case to one or other of these groups.

Simple Schizophrenia.—Simple schizophrenia usually shows itself in early adolescence by an insidious change in the personality of the patient. A marked loss of interest in work and social activity is noticed. At school the patient may neglect his studies. He seems to lack concentration. He is dreamy and detached. He does not take part in games, and he has no friends. He becomes quiet and moody. He seems lacking in ambition. Later he shows an inability to assume responsibility. He may become negligent in his personal habits and careless in his work. There seems to be a general impoverishment of the mind which shows itself in a state of apathy, a lack of animation, and a certain childishness and simplicity.

The absence of the acute symptoms often makes it possible for the patient to remain at home, and sometimes he is able to earn his living, provided the work does not call for initiative and responsibility. Many of the simple schizophrenics, however, are shiftless and erratic. They are unable to remain in employment for any length of time. Some are easily influenced, they fall into bad habits, and drift into crime.

Acute episodes occur in the course of the illness, characterised by mental confusion, vague persecutory delusions, and hallucinations.

Hebephrenia.—The hebephrenic type usually begins before the age of twenty. A shallow depression with feelings of guilt about sexual matters is often the first symptom that calls attention to the patient's condition. Hypochondriacal delusions of a fantastic character and ideas of persecution with hallucinations of hearing are often prominent symptoms.

The patient begins to show marked signs of mental deterioration in an early stage of the illness. His conversation becomes incoherent. He becomes profoundly apathetic, and his conduct is characterised by strange antics and impulsive acts. Usually the condition ends in a profound state of dementia.

Katatonía.—The katatonic form shows a more distinct clinical

entity than any of the other types of schizophrenia. The onset of the illness is often acute. After a state of depression with lack of interest and apathy, the patient sinks into a state of stupor in which all his activities are reduced to a minimum. He lies motionless for weeks or months, mute and inaccessible. He makes no effort to do anything for himself, and he may require to be fed and dressed, and cared for in every way.

This state of complete inactivity may suddenly change into one of wild excitement, in which the patient, in a state of frenzy, behaves in a wildly impulsive way. He may make a sudden assault upon his nurses, or he may attempt suicide, or mutilate himself in the most gross manner. He may express delusions of persecution or feelings of influence. He hears hallucinatory commands upon which he acts. Delusions of a mystical and religious character are frequently expressed. The patient feels that he is under Divine guidance, and God manifests himself to him in visions and dreams.

After a time the excitement subsides and a period of remission may follow, or the patient may relapse once more into a state of stupor. Many of these cases end in a state of dementia.

Paranoid Forms.—The paranoid form usually begins later in life than the types already described.

Delusional ideas form the prominent symptom in this type. These delusions may take any form. They may be persecutory or grandiose in character, but whatever form they assume, they are usually quite unsystematised and often extremely bizarre in character. Hallucinations usually occur and the patient's conduct is often completely dominated by his hallucinatory experiences. Paranoid schizophrenia is distinguished from the other paranoid reaction types of mental illness by the fantastic character of the delusions, the disharmony between the patient's mood, and the ideas he expresses, and by the marked deterioration in the personality which occurs.

Any type of anti-social conduct may occur as a symptom of schizophrenia. The alienation from the social environment, which is such a marked symptom in the illness, tends to make the patient careless of his social obligations and liable to satisfy his immediate desires without regard to the welfare of others or to his own safety. In the general emotional deterioration which occurs, the moral sentiments are disorganised and no longer restrain the instinctive impulses. The patient's thinking is illogical, and his actions lack adequate motives, and it is particularly characteristic of schizo-

phrenic conduct that it appears inexplicable and unreasonable. The patient himself is often unable to suggest any reason for his actions. When pressed, he may say that "something made him do it". Not infrequently his explanation is that he acted under some mystical influence, or at the command of a hallucinatory voice. Under the belief that he is the Messiah, and that he must save the world by self-sacrifice, he attempts to take his life. As God, the supreme ruler of the Universe, he has power of life and death over all, and he does not hesitate to punish, or even kill anyone who offends him or attempts to frustrate his designs. Unconscious conflicting feelings of love and hate towards parents and parental figures are prominent features in the psychopathology of schizophrenia, and may result in the patient making violent attacks upon one or other parent, or upon his sweetheart. Or, overwhelmed with unconscious guilt, he may inflict severe mutilations on himself. These mutilations sometimes take the form of an actual or symbolic castration, or the patient may actually take his own life. Wedding day suicides are often of this type. The failure on the part of the patient to reconcile his love and hatred is probably the unconscious motive behind the sexual assaults which the schizophrenic patients sometimes commit.

Aggressive and self-punitive tendencies exist simultaneously in the patient's mind, so that his behaviour is often contradictory and incongruous.

A schizophrenic patient in an institution, in a state of excitement, struck his physician, who was talking to him, a violent blow on the jaw. He did not press the attack, but appeared to wait for the physician to retaliate upon him. When the physician did not do so, the patient burst into tears, and in a state of extreme agitation, called upon the physician to "strike him in the belly".

Although, in some instances, a blind, unreasoning impulse seems responsible for the patient's criminal acts, there are many cases in which there is evidence of careful planning and premeditation, and very frequently the patient is able to give a clear account of what occurred, but even when the act shows evidence of deliberate planning, the impression created is that the author of it was an automaton and that he was motivated by impulses beyond his understanding and control.

Although crimes of violence occur as symptoms of schizophrenia, it must not be thought that criminal violence is a characteristic symptom of this type of mental illness. On the contrary,

the majority of these patients are quiet, timid and apathetic. They lack the initiative to assert themselves, and their strongest desire seems to be to cut themselves off from contact with the outside world.

When the schizophrenic transgresses the law, the offence is often a technical one, and arises, not from criminal intent, but from his inability to cope with life's problems and to fulfil his social obligations. The enfeeblement of his mental powers and his lack of good sense, makes him yield readily to temptation, and he is often a helpless tool in the hands of unscrupulous associates.

It must also be realised that while the majority of these cases end in dementia, in a considerable number, the illness is arrested, and in quite a number of these arrested cases, the personality is retained at a good level, and the patient is able to maintain ordinary social relationships.

In simple schizophrenia where the absence of gross conduct disorder allows the patient to remain under home conditions, he is liable to become a burden upon society unless he is adequately supervised. Unable to compete on equal terms with his fellows in the labour market, he drifts into the ranks of the permanently unemployed. He becomes a vagrant, a street pedlar, or a beggar. He may steal, not because he is inherently dishonest, but because it seems to him the easiest thing to do.

Often minor crimes are committed in this type of illness while the patient is under the influence of alcohol.

Sometimes the patient, preoccupied with his own thoughts and out of contact with his environment, commits a criminal offence almost without realising what he is doing.

A man of 50 years of age was charged with exposing himself indecently at an open window.

In the routine examination by the police surgeon, the patient's peculiar attitude attracted attention, and he was examined by a psychiatrist. At his trial, sentence was deferred on condition that the patient subjected himself to psychotherapeutic treatment.

The history showed that since adolescence he had been extremely shy, sensitive and secretive. He had never married, and he had few friends. His only interest apart from his work—which was that of a minor railway official—was music. His work was purely of a routine character, and although he must have been a man of good intellectual endowment, he had never been able to earn promotion.

He had a morbid interest in his own health, and he was in the habit of dosing himself with patent medicines and special medicinal

foods. He had ideas of reference, but these had never affected his conduct to any marked degree. He felt that people were looking at him in the street, and sometimes he thought people talked about him. He knew that he was regarded as eccentric by his workmates, and sometimes he was the butt of their jokes, which were usually harmless and kindly.

In his conversation he was inclined to be rambling and vague. He showed considerable blunting of his emotions. He was entirely lacking in ambition, and he had little animation and no spontaneity.

His explanation of his offence was that, in the interests of his health, he had been doing physical exercises in front of an open window. He thought it was possible that he had exposed himself, but he denied that he had done it intentionally.

A young man of 22 years of age was charged with murdering his sweetheart, by striking her on the head with an iron bar.

His history showed that there was no history of mental illness in his family.

He was dull at school, and his teachers noticed that he was very timid and easily frightened. He worked for a time as an office boy, and later he obtained a post as an assistant storeman in an engineering shop, which he held until his arrest. His parents had noticed that his behaviour had been peculiar for years. He had always been extremely asocial and reticent. He spoke very little at home, and when visitors came to the house, he either stayed in a corner by himself, or he left the room. Before he left the house he was in the habit of looking to make sure there was no one in the street. If he saw anyone standing near his house, he would turn back and wait until he could go out unobserved.

He had also been observed by his parents, to stand in front of a mirror, partially undressed, grimacing, talking to himself, and masturbating.

He had a violent, explosive temper. Some time before his arrest, in the course of an argument with his mother, he picked up the poker and struck her on the leg. On another occasion his sister criticised the manner in which he was cutting bread, and the patient rushed at her with the breadknife and attempted to stab her.

Another member of the family described the patient as "the kind of chap you never knew what he would do if he got into a temper". "His mind seemed to be miles away from the conversation".

A neighbour described how she had looked upon the patient as queer, and how she had seen him laughing to himself, and how at times when she met him in the street, he would greet her cordially: at other times he would pass her without recognition. She had noticed that sometimes when he was walking along the street, he would take

a curious little run. His employer thought that he was below the average intelligence. He had noticed that he was inclined to be dreamy, and that he seemed to have difficulty in grasping instructions. He was very moody, and given to violent outbursts of temper in which his language was obscene and threatening.

When examined, the patient was clear in his mind. His memory seemed unimpaired, and he was able to give an account of his history and of the events connected with his crime. He professed great affection for the girl he had killed, but he said that for some time he had been very disturbed in his mind because she would not agree to marry him. She seemed fickle, and he felt that she had him "dangling on a string". It occurred to him that if he gave her "a fright" it would bring her to her senses, and so for some time before he killed her, he was in the habit of carrying an iron bar in his pocket with which he intended to threaten her when a suitable opportunity occurred.

On the night when the crime was committed he met the girl. He had the iron bar in his pocket. They had a quarrel, and the girl said that she would not go out with him any more. She laughed at him in a scornful way. He struck her on the head with the iron bar which he had brought with him, and after that he said that he "lost his head completely".

The patient's manner was very childish. He showed a complete lack of appreciation of the seriousness of his position. He said that when he saw anyone bending down in the street, he had an impulse to strike him on the head. He also said that sometimes he got out of bed in the middle of the night to look at himself in the mirror. He said that his own family regarded him as peculiar, and that his brother and sister sometimes called him "looney".

While in prison awaiting trial, he developed further symptoms of mental disorder. He was observed to laugh and to talk to himself. He made peculiar gestures and grimaces in a foolish way. He complained that the prisoners and the warders were talking about him and commenting about the shape of his nose, and he expressed the fear that he would be attacked. In spite of his situation, he was usually in the best of spirits. He said that he had written a song which he was going to submit to a composer for his opinion. He was also going to compose the music for his song, although he admitted that he knew nothing about music. He said that before he was sent to prison he felt that people were saying nasty things about him.

The court found him insane and unfit to plead, and he was sentenced to be detained during His Majesty's Pleasure.

A man of 28 years of age was charged with the crime of attempted murder. He had broken into a house occupied by his sister and

assaulted her four young children by striking them on the head with an iron cleaver.

A medical examination of the accused showed that he had typical symptoms of schizophrenia.

He was a pleasant, friendly, young man. On ordinary topics his conversation was coherent and logical, but when one touched upon his delusions, his talk became disjointed, illogical, and at times incoherent.

He was able to give an account of the offence with which he was charged, and an explanation of his reasons for his assault upon the children. He said that the children were "outside the radiance of people about them" and that the only way to get them "within the radiance" was to kill them. He was convinced that he was morally right in what he had done. It was the only course available for him to take. He said, "They would be lost if I did not do something." He admitted that he heard "voices" which, he thought, came from "the black people". The "voices" told him to kill someone called Peter. He said that he "felt a great number of voices bearing down upon him as if he were to come to some position". He also received messages from the German people. He could not explain how these communications were made, but he was sure that the German people had a better knowledge of him and his fears than people around him.

At his trial he was found unfit to plead, and was sentenced to be detained during His Majesty's Pleasure.

PARANOID REACTION TYPES

Of all the standard devices used by the mind to deal with internal conflict, the mechanism of projection, by which unacceptable impulses are attributed to external sources, is one of the most frequently employed. The use of this mechanism in psychotic illnesses, in which the relations between the individual and external reality are disturbed, gives rise to delusions.

Delusional formation occurs at one stage or another in most types of psychotic illness, but there is a group of psychoses in which the formation of delusions is the predominating symptom, and it is these that are grouped under the term paranoid reaction types. The older psychiatrists isolated certain syndromes within this group which they regarded as distinct clinical entities to which they gave special names, but at the present time, it is usual to include all the paranoid reaction types under two headings: paranoia and paraphrenia.

Paranoia is a chronic mental illness which develops gradually

over a long period. The delusions, which are a characteristic symptom, are well systematised. It is an essential characteristic of the illness that the memory and the intellectual processes are well preserved. Hallucinations do not occur, and the essential core of the personality is preserved.

The study of the personality of persons who develop this type of illness usually reveals trends which help to explain the development and the clinical features of the disease.

In many cases a study of the patient's life shows that his general attitude to others has been one of suspicion, and that he has always been ready to attribute enmity and hostility to those with whom he has been associated. Persons of this type often appear shy, timid and sensitive, but these outward characteristics often conceal an underlying feeling of self importance and a desire to lead and to dominate. Sometimes one finds that the patient has an exaggerated idea of his own abilities, and that his failure, through incompetence, to realise his ambitions, appears to be the starting point of a delusional system, the purpose of which seems to be to explain and excuse his failure in life.

Not infrequently a painful experience over which the patient has brooded until its true significance has become completely distorted, appears to have been the focus around which his morbid thoughts have developed. Thus, a technical offence which leads to an appearance in the police court, may sometimes be the starting point of a system of persecutory delusions. A failure in an examination, or in business, may initiate, in a predisposed person, a searching ruminative state of mind which gradually develops into a chronic delusional state.

There are, however, certain cases in which a study of the personality of the patient fails to show any outstanding characteristics, and it is not always possible to find evidence of any incident or worry in which the patient's illness has originated.

While actual incidents in the patient's life may appear to be closely related to the development of the illness, these incidents only act as precipitating factors which activate the unconscious forces from which the illness springs and takes its character. Freud, on the basis of his psychoanalytic study of these cases, expressed the view that paranoia results from unconscious homosexual tendencies which are repudiated by the individual and then projected in the form of a delusional system.

Glover expresses the Freudian view thus: "Paranoia, however,

is almost always connected with strong unconscious homosexual interests, which are denied and then projected. There are a number of stages in the development of this defence against homosexuality, but the essence of the matter is contained in the formula of delusional denial—"I do not love him, he hates me". The homosexual defence is, however, not just the denial of a potentially active adult system, but the rejection of a reinforced, but repressed, infantile phase of homosexual development."

Although paranoid types of personality are very common, paranoia, in its fully developed form, is not a type of illness commonly met with in psychiatric practice, and these cases are comparatively rare in mental hospitals. There must be many cases of well developed paranoia which never come under medical observation. The patient's formal social behaviour may show little disturbance, and this, combined with the preservation of his intellectual faculties, makes it possible for him, in many instances, to live a fairly normal life at home, or even to carry on his trade or profession for many years after his illness has developed.

Although many paranoiacs are querulous, suspicious and aggressive, many maintain friendly relations with those with whom they are in contact, and even with persons whom they believe are taking part in their persecution.

The paranoiac patient in a mental hospital is often on very good terms with those around him. Although firmly convinced that his detention in the hospital is unjust and illegal, he is yet able to maintain friendly and even cordial relations with the physician who refuses to release him.

A professional man, who believes that for years he has been victimised by the medical profession, who, he says, "make use of him" without his permission and without giving him the remuneration to which his services entitle him, is on the most friendly terms with the nurses and physicians in the hospital in which he is a patient. At times he interviews the Medical Superintendent and demands his discharge. He makes it clear that he holds the superintendent responsible for the injustices to which he has to submit, but the physician's refusal to accede to the patient's request for discharge, does not deter the latter from carrying out very useful work in the hospital, at considerable inconvenience to himself.

The degree in which the patient's conduct shows a departure from the normal standards, depends on the character of his

delusions and the stage of development which his illness has reached.

In those cases which form the majority, the illness is of gradual development, and there is usually a prodromal period during which the patient is uncertain about the truth of the delusional ideas which are slowly taking form in his mind. He is alert and suspicious. He feels that his suspicions are well founded, but he is willing to agree that the incidents which have aroused them, may be capable of an innocent interpretation.

During this stage of the illness the patient may show very little outward signs of abnormality. He does not usually express his half formed delusions, because he realises that they may not be believed. He may appear preoccupied, and perhaps worried, but he continues his work, and his social relations are not usually grossly disturbed. He may decide to apply tests, with the object of proving or disproving his suspicions, but as his conclusions are determined, not by experience, but by unconscious mental processes, the results of the tests always seem to confirm his suspicions. At times he is completely convinced of the truth of his delusions: at other times his ideas can be shaken for the time being by discussion and reasoning.

This ebb and flow process may last a long time, and even when the illness is fully developed, periods of acute mental tension during which the patient is entirely dominated by his delusions may alternate with periods in which the morbid ideas appear to be in abeyance. These remissions in the illness are rarely permanent. When conviction has replaced suspicion, the patient may be forced to act in accordance with his delusional ideas. What action he will take will depend upon the nature of the delusions and upon his general character. If he has the delusion that he is being poisoned, he may consult a doctor, or he may adopt precautionary measures to ensure that his food is not adulterated in any way. If he is acted upon by electricity, he may insulate his bed. If gasses are pumped into his room, he may try to make the room gas proof. If his persecutor is some person accessible to him, he may confront him and ask for an explanation, or he may complain to the police. If the police fail to take action, he writes to a still higher authority. If he is by nature aggressive, his first protest may be an attack upon his aggressor. If he is timid, he may decide to flee from his imaginary persecutors, or he may, in a state of despair, commit suicide.

In some cases, a state of acute mental tension, in which the

patient's conduct is almost entirely motivated by his delusions, may continue for years, but in most cases, sooner or later the patient's mind affects a compromise between the demands of reality and those of his fantasies. The delusions remain, and they continue to influence his thinking and his conduct, but he adjusts himself to the situation as a normal person may do to any enforced interference with his normal mode of life. He begins to participate, to some extent, in normal activities, and he attains a state of resignation, and even at times contentment. This evolutionary process occurs in many paranoiacs after their admission to a mental hospital. At first they are indignant and resentful, and some are combative and aggressive, but gradually, in the course of months or years, they adapt themselves to the life of the institution, and often participate with enjoyment and even enthusiasm in its activities. When this stage is attained, the patient's conduct, except for certain eccentricities, shows little abnormality, within the limit of his circumscribed life.

There are, however, certain cases which take a long time to reach this stage of tranquility. For them, the whole world is hostile and menacing, and everyone is an active agent in their persecution. Everything they hear has a double meaning. Every action done by anyone in their presence is misinterpreted as an insult, or a symbolic assault. They are mocked and humiliated. Their characters are besmirched, and life for them is a continuous battle against tyranny and persecution.

The paranoiac's persecutors may be a single individual, but usually it is a body of persons. Sometimes it is the Jews, sometimes the Free Masons, the Medical Profession, the Catholic Church, or the Government. At times it may be an undefined body specified by the patient as "they".

Criminal offences of the patient suffering from paranoiac states are usually the direct outcome of the patient's delusions. When we consider the relentless persecution to which the patient believes he is subjected, it is surprising that crimes of violence in these cases do not occur more frequently than they do. No doubt crimes against the person would be committed more frequently by paranoiacs were it not for the fact that, in many instances, the patient is naturally law abiding, so that he usually tries by constitutional means to obtain redress from his wrongs before he resorts to violence. The fact that the patient's personality is retained and that his moral sentiments are preserved, also explains why criminal

offences only occur in a small proportion of cases of this type of illness.

In East's series of 66 cases of paranoiac patients who committed crimes, 12 committed crimes against the person, 10 violence to property, and 6 were cases in which violence was threatened. Fifteen per cent. committed acts of dishonesty, such as theft and office breaking. The remaining offences included vagrancy, use of obscene language, libel, sending obscene matter by post, neglect of family, obstruction and drunkenness.

East points out that no case of sexual offence occurred in this series, and he remarks that this is a point of interest in view of the fact that the delusions of these patients are often sexual in character.

Offences against the person may arise from different motives. They may be the result of the patient's natural impulse to retaliate upon his persecutors and mete out to them the punishment he believes they deserve, or he may resort to crime from altruistic motives. He may believe he is benefiting his country or the world by killing a tyrant. He may commit his offence not out of ill will towards the victim, but because he has failed to obtain redress for his injuries by constitutional means, and at last he comes to the conclusion that by committing a crime which will lead to his arrest or trial, he will have an opportunity of ventilating his grievances in court. The offence may be premeditated and carefully planned, or it may arise out of the impulse of the moment.

A man who believes that his wife is unfaithful to him, enraged by her denials of his accusations, may strike her impulsively, or he may lie in wait for her paramour and kill him.

Offences against property may be motivated by revenge, as, when a deluded patient attempts to get his own back on his persecutor by throwing a stone through a window in his house, or they may be the result of the patient's efforts to relieve his trying situation. If he believes that the interference to which he is subjected comes from his neighbour's house, he may attempt to destroy the house, perhaps by setting fire to it in the hope that the interferences will cease when their source has been destroyed.

The patient's persistent efforts to get into personal touch with his persecutors or with the authorities may lead to minor offences. He may try to force his way into the magistrate's room in order to place his case before the legal authorities. He may interrupt a royal procession in an attempt to obtain a hearing from an impor-

tant personage. He may denounce his enemy in the street and so render himself liable to a charge of breach of the peace, or he may send letters containing defamatory statements or obscene matter through the post. Occasionally the patient comes into conflict with the law through a technical offence. He is so preoccupied with his delusional system that he neglects to comply with the law in some way or other.

The following case illustrates the development of paranoia, and some of the disorders of conduct which may occur:

The patient was a man of 38 years of age, an accountant by profession. He was married and he had three children. He had a somewhat harsh upbringing by a tyrannical father.

Until his illness began he was a successful business man. He was seriously minded and most abstemious in his habits. He was sociable and well liked by his friends and acquaintances. He married when he was 28 years of age. Until his illness began his married life was very happy.

A year after his marriage he went to a Balkan country to take a post with a mining firm. The work entailed considerable anxiety and much responsibility. An official at the mines was shot by assassins and the patient was a witness in the Government investigation which followed. His wife thought that this may have been the starting point of his mental illness, although, at the time, she did not regard his behaviour as abnormal. Looking back in the light of later developments, however, she thought that his conduct, in certain respects, might have been influenced by morbid apprehensions, as, for instance, when on one occasion, while he was abroad, he made over all his money and his investments to her, explaining that he feared he might be arrested by the Government of the country in which he was working, and that his money might be confiscated. At the time his wife thought that this might happen, but later she was inclined to think that the patient's fears were groundless.

He gave up his post abroad and returned to this country where he took up poultry farming—a subject in which he had become interested while he was abroad. This venture proved unsuccessful, and the patient gave it up after six months. He complained that his hens and his eggs were being stolen. There was no evidence that this was happening, and his wife concluded that her husband had delusions.

After this he was idle for two years. He made no attempt to work, but he read a great deal. By this time he had developed well marked mental symptoms. He was unduly irritable. He developed ideas of reference. He took wrong meanings out of innocent remarks. On one occasion, in a state of rage, he accused his wife of lying to him, and

struck her. Immediately after he had done this he was overwhelmed with remorse, and apologised to her. About this time he began to complain that visitors to the house were drugging him.

He obtained a post in an accountant's office, but he had not been there long when he was discharged for striking a fellow employee.

Soon after this, the company with whom he had formerly been employed, invited him to take a post with them. He did so, but within a week he was asked to resign, because at a meeting of the directors of the firm he flew into a violent rage when someone questioned an opinion he had expressed.

His brother persuaded him to see a doctor, and he did so. He talked freely about his delusions to the doctor, who advised him to go into a mental hospital, but he refused to do this. He agreed, however, to undergo a course of psychotherapy. He visited the psychotherapist on seven or eight occasions, and then he became convinced that the doctor was involved in his persecution and he gave up the treatment.

He was successful in getting another post which he held for six months. At the end of this time he was discharged for quarrelling with one of his colleagues.

His delusions developed and began to influence his conduct more and more. He became increasingly violent. On several occasions he struck his wife. On one occasion he disapproved of a business letter which his wife's lawyer had sent her. The letter did not contain anything which a normal person could regard as objectionable, but the patient criticised it as most unsuitable. He said that he would demand an apology from the lawyer, and if the latter did not give it, he would "give him a good hiding". He was convinced that he was being drugged, and he complained to the police, saying that drugs were being put in his food. The police advised him to see a doctor, and he agreed to do so in the hope that the doctor would be able to treat him for the effects of the drugging.

The doctor whom he consulted arranged for his certification, and he was admitted to a mental hospital.

For some time after his admission he proved a very difficult patient. As a protest against his detention in hospital, he refused to take food, and for some time he had to be forcibly fed.

He talked freely about his persecutory delusions. He said that he had been subjected to drugging for some years. The last occasion on which he was drugged, he said, was a few days before his admission to hospital, when he had had a meal of brown bread, butter and cheese. He thought that the drug was contained in the butter. Shortly after this meal he felt that there was "something at the base of his stomach" which should not have been there. It was as if "his nerves were being irritated". He had never had his food examined,

but he said that, on one occasion, he had taken a sample of bath water to the city analyst who reported to him that it did not contain any obnoxious substance. He said quite frankly that if he could find the person who was responsible for drugging him, he would "smash him". He related some of the difficulties which he had experienced with some of the men he had worked with. He said that in one office, a fellow employee opened a desk in such a way as to make a noise which interfered with the patient's work. He asked this man to leave the room, which he did. When a second man came in to open the desk, the patient concluded that a deliberate attempt was being made to annoy him, and he knocked the man down.

He protested vehemently against his detention in hospital. He requested to see the Sheriff who had signed the warrant for his admission. He declared that he was being fed during the night while he was unconscious under the influence of gas. He complained that he heard noises in the wainscoting of his room. The nurses to whom he spoke about the matter suggested that the noises might be due to the presence of rats or mice. The patient, however, rejected this explanation and maintained that some human agency was at work and that a deliberate attempt was being made to test his mental state and to discover how he would react to a particular stimulus.

He was a man of good intelligence. His memory was unimpaired, and he conversed freely in an interesting and intelligent way upon many subjects. He was quite convinced of the reality of his delusional ideas, and he repudiated the suggestion that his violent behaviour before his admission was a symptom of a mental illness. He held that he was quite justified in attacking and punishing anyone involved in his persecution.

After about a week in hospital, his attitude to the medical and nursing staff changed from resentment and antagonism to friendly cooperation. He ceased to speak freely of his delusions, and he began to take an interest in the affairs of the institution.

After four months residence in the hospital he was discharged at his wife's request.

Paraphrenia.—Paraphrenia takes up a position midway between paranoia and paranoid schizophrenia.

It differs from paranoia in that the delusions are less well systematised and more fantastic in character. Hallucinations, which are absent in paranoia, are common symptoms of paraphrenia, and the personality shows a degree of deterioration which does not occur in paranoia. On the other hand, the profound dementia, which sets in comparatively early in paranoid schizophrenia, is absent in paraphrenia, or may only occur in the later stages of the illness.

The following case illustrates the clinical features of paraphrenia:

A woman of 57 years, of good social standing, had been regarded by her friends for years as eccentric and peculiar. Her arrest, on a charge of breach of the peace, led to her certification and admission to an institution.

She had been brought up in comfortable circumstances and she had taken a medical degree although she had never practised her profession. Soon after her graduation she developed delusions. She spoke of "references in the press" which were directed against her, and she singled out the editor of *Punch* as the chief offender. She accused various clergymen of being in the plot, and said that they made reference to her from the pulpit. She spoke of a "gang" which was engaged in activities against women and she made it her life's work to expose this "gang" and put an end to their illegal activities. The "gang" she said was responsible for a vast traffic in suicide, which she referred to as "molestation suicides". What she called the "filth press" was closely involved in the campaign. The members of the gang were well aware of her efforts to expose them, and this led them to persecute her relentlessly. She believed that the police were conversant with everything that was going on and that she had their protection. When she walked in the street, hundreds of policemen were stationed there to keep her under observation and to ensure that she did not suffer molestation. Her enemies were constantly spying upon her through telescopes, and they made frequent attempts upon her life, sometimes by means of a "death ray".

She was well known to the police because of her frequent interviews with them and the numerous letters she sent them.

Some years ago before her arrest, in an attempt to escape from her persecutors, she climbed on to the roof of a building, from which she had to be rescued by her medical attendant.

She was finally arrested because she disturbed her neighbours by persisting in blowing a police whistle during the night.

For a time after her admission to hospital she was very friendly in her attitude to everyone. She assumed that she had been sent to the hospital to escape the persecutions of the gang, and she was certain that the hospital authorities were cooperating with the police to protect her. Later, however, when she discovered that her activities were being curtailed, she came to the conclusion that far from wishing to help her, the superintendent of the hospital and everyone in it were in league with her persecutors.

She was well endowed intellectually. She expressed herself with great fluency in conversation and in writing, and she was regarded by her intimate friends as charming and kindly, if at times, some-

what trying. She wrote numerous and voluminous letters to the police, to the Secretary of State, and to the King. In one of these letters she described the hospital as "Hell let loose", and the Physician Superintendent as "a defective of affable manner, who will stick at nothing—not even at using his discretionary powers to put the silence of Death on any who dare to report, as he owns they are 'entitled' to do 'what goes on inside the place'. The reign of anarchy and terrorisation continues year in, year out. The police," she said, "could do nothing, for the scandal is outside their jurisdiction."

In another letter, addressed to the Secretary of State for Scotland, she wrote:

"This spring I drew the attention of H.M. Commissioner to veiled allusions to himself in *Punch*, and recognisable (tho' not unkind) portrait caricature. He took it up with the paper with some success. I think you may be interested in *current issue* of that periodical (subsequent to kind King's Senior Commissioner's annual round of this 'Royal' Establishment now so widely known as Muddle-to-Death. The point of interest is the *perfect likeness* to Dr.— (with characteristic eyebrows) seen at foot of picture, page 236, gazing affably from bag at the word 'Whitehall'."

After a period of four years' residence in hospital, the patient was liberated on probation, but her probationary period had to be terminated because of her unreasonable behaviour. Her conduct became more and more dominated by her delusions. To protect herself from the "death rays" she stuffed her mouth, ears and nostrils with cotton wool, and covered her eyes with brown paper. She tried to keep herself awake at night because she believed that she was better able to resist the "rays" when she was awake. Everything she read in the newspaper referred to her and the conspiracy against her. In addition to the "death ray" she was assailed by "fumes and fungus attacks". On several occasions she said that the end of the world was imminent. Her delusions became more and more fantastic. She spoke of a great system of "tunnels and sewers filled with mountains of gold" which she said existed under her former home. She became depraved in her personal habits.

Her physical strength deteriorated as a result of exhaustion. She refused to take her food and had to be forcibly fed. She died of cardiac disease six years after her admission to hospital.

In certain cases of suspected paranoia, the diagnosis depends upon the truth or otherwise of the patient's statements, and so it is necessary to obtain evidence from other sources. Even with all the evidence available at his disposal, the physician may have difficulty in coming to a decision about the true diagnosis.

The following is a good example of such a case:

A man of 45 years of age was arrested on the charge of murdering his wife by stabbing her on the body with a knife. At his trial, a plea of guilty to culpable homicide was put forward on his behalf. The plea was accepted, and he was sentenced to seven years' penal servitude.

The following information was obtained in an examination which was carried out a week after his arrest.

The patient was employed as a storeman and was regarded as a capable and reliable workman. He married when he was 25 years of age, and he had a family of ten children, six of whom were alive. His physical health had always been good.

He had an unhappy married life. His wife was very improvident in her habits. She spent the money her husband gave her in betting. She neglected her home. She pawned her husband's and her family's clothes at the beginning of each week and redeemed them from the pawn when her husband paid her his wages at the end of the week. She bought a large quantity of goods for which she could not afford to pay, and at the time when the offence was committed, the accused was still paying off the debt. He had not even the satisfaction of having the use of the goods bought, because his wife had pawned them long before they had been paid for. On several occasions, she had deserted the home and remained away for considerable periods. She was out a great deal in the evenings, but she rarely went out with her husband. Often the accused was left alone in the house, and his children noticed that he brooded a great deal over his unhappy situation.

The accused said that for some time he had suspected that his wife was carrying on an illicit friendship with another man, or with other men. His reasons for this belief, however, were not very convincing. He related that two years before his arrest he saw his wife standing on the pavement with a man who was a stranger to him. This incident aroused his suspicions. He mentioned the matter to his wife, but she denied that the incident had occurred. The accused, however, said that he was quite certain that it was his wife, and not someone else whom he had seen.

Six months before his arrest, his wife left him and went to London. She left a letter addressed to him in which she told him that she had contracted debts to a large amount. She confessed, in her letter, that she had not been a good mother or a good wife. After her departure the accused found that the debts she had contracted amounted to over £100. His wife's desertion confirmed the suspicions aroused by the incident in the street when he saw her with the strange man, and he came to the conclusion that she had run away in this man's company. He taxed her with this in a letter, but she wrote denying the

allegation. He accepted her denial and begged her to come home, sending her her railway fare to enable her to do so. His wife returned home, but in the meantime, the accused had obtained information from certain friends which confirmed in his mind the suspicions he had formed of his wife's infidelity. The accused alleged that these friends had told him they had seen his wife in the company of another man. He was unable to give the name of the man concerned. He said that he brooded a good deal over this matter, and on several occasions he followed his wife when she went out, but, on each occasion, she was able to elude him.

Again his wife deserted him, and again he wrote asking her to return home, and she did so after an absence of four months. This was three weeks before her death.

On her return she explained that she had left him because the neighbours were criticising her over her previous desertion of her husband.

On the day when the offence was committed, the accused came home as usual to his midday meal. His wife's behaviour aroused his suspicions. She did not talk to him or to the rest of the family as she usually did, but instead read a book. The thought came into his mind that she was planning to leave him again. He had given his wife a sum of money with which to buy wallpaper. When he left his house after his midday meal he decided to wait at a street corner where he had a view of the shop in which it had been arranged that she should buy the wallpaper. He explained that he wished to satisfy himself that she would put the money to its proper use. While he was standing in the street, he saw a man approaching him whom he was certain was the same man that he had seen previously in his wife's company. He came to the conclusion that his wife had arranged a rendezvous with this man and he decided to follow him. He followed the man for a considerable distance and then he decided that he would return home in order to see that his wife was still in the house. On his way home he met his wife in the street. She expressed surprise that he was not at his work, and he pretended to her that he had been sent by his employer on an errand and that he had decided to pay a visit to his home before returning to work. He noticed that his wife was not going in the direction of the shop where she was to buy the wallpaper and he also noticed that she was carrying a parcel which he thought she was trying to conceal with her handbag. He parted from his wife, but he decided to follow her. After following her for some time he lost sight of her but later they came face to face at a street corner. She accused him of following her and they had a heated argument in the street. His wife then turned to go home, and the patient accompanied her. When they came to the tenement where they lived his wife refused to go into the house and said she was

going to run away. A further argument ensued, and in the end the accused persuaded his wife to accompany him into the house. Here the discussion was continued.

The accused asked his wife what the parcel she was carrying contained, but she refused to tell him. He opened the parcel himself using a knife to cut the string, and found that it contained food. This seemed to confirm his suspicions that his wife was going to leave him. He thought that she had taken these provisions to sustain her on her journey. He was also certain that she had arranged to meet the man whom he had seen loitering in the vicinity of the house and that she intended to run away in his company. He demanded an explanation from her. She refused to reply, and at this point, the accused said he "lost his head" and that was all he could remember. He had, in fact, attacked his wife with the knife he had used to cut the string of the parcel, and he inflicted such serious injuries upon her that she died.

Although medical reports on the accused's mental state were submitted, medical evidence was not led in the court at his trial for he pled guilty to culpable homicide. The plea was accepted by the crown and he was sentenced to seven years' penal servitude.

This case has been reported in some detail in order that all the facts available on which an opinion as to the man's mental condition could have been expressed, should be presented.

The assessment of the accused's mental state was dependent mainly on whether his suspicions of his wife were well founded or whether they arose from delusions of jealousy. It was impossible to decide this point on the evidence available. The members of the accused's family were unable to throw much light on the matter. His daughter was reluctant to believe that her mother was guilty of marital infidelity, but she admitted that someone had told her on one occasion that her mother had been seen with a certain man.

But in dealing with a case of this type, one must consider not only the facts, but also whether the attitude adopted by the patient to the situation seems reasonable. A man may express a belief which may or may not be a delusion, but even if his belief is not a delusion, but is in fact true, the evidence he brings forward in support of his belief may be so trivial that it would not convince any normal person, and his behaviour arising out of his belief may be so exaggerated and unreasonable that in itself it constitutes evidence of mental disorder. In the case under review, it is quite possible that his wife was unfaithful to him, but it is certain that a well balanced person would not have behaved in the same circumstances as the accused did.

ORGANIC REACTION TYPES

In the organic reaction types of mental illness, the mental disturbance is the result either of a primary pathological process in the brain, or of disease, or disturbed function of the bodily organs reacting upon the brain.

An example of a condition in which the primary affection is localised in the brain, is General Paralysis of the Insane, in which infection of the central nervous system by the spirochaeta pallida, the organism causing syphilis, gives rise to inflammatory and destructive changes in the nervous tissues.

Myxoedema, a disorder of the thyroid gland affecting the nervous system, is an example of a condition in which the affection of the brain is secondary to disease in some other part of the body.

Organic reaction types of mental illness fall into two main clinical groups: the acute and the chronic.

In the acute form, the cerebral disturbance giving rise to the mental symptoms, is usually toxic or irritative. Delirium tremens and the deliria associated with acute fevers, are typical examples of the acute organic reaction type.

Of the chronic conditions, senile mental deterioration is a typical example. Here the nervous tissues are destroyed, and the clinical picture is one of progressive mental and physical deterioration.

Mental illness arising from organic brain disease may simulate any form of functional mental illness, but when the organic process is well established, it gives rise to characteristic mental changes, which usually enable the clinician to distinguish the organic types from the functional forms of mental disease. The characteristic mental symptoms referred to are: confusion of mind with complete or partial disorientation, impairment of the memory, enfeeblement of the intellect, emotional facility, and deterioration in the social and moral conduct of the patient. In addition to these mental symptoms, one may expect to find the physical symptoms associated with the particular type of physical disease causing the illness.

In the early stages of the disease, however, before gross deteriorative changes have occurred in the nervous system, and in cases where the lesion is localised in certain parts of the brain, physical symptoms may be absent for a time, and the mental symptoms may be very indefinite in character.

The clinical picture in the acute reaction types, as already said, takes the form of delirium. Mental confusion, which is more marked at night, is always present, and may be so severe that the patient has no knowledge of time, of place, or of those around him. There may be great excitement, with extreme restlessness. The patient's power of concentration and his comprehension are grossly impaired. His conversation is rambling, and sometimes completely incoherent. Anxiety assuming the intensity of acute terror, is the prevalent emotional state. Terrifying hallucinations, particularly of the visual sphere, cause acute apprehension, and may cause the patient to rush blindly from his room, or throw himself out of the window. He may make a sudden, violent attack upon his nurses, under the impression that they are enemies about to destroy him.

Confusion, terror, and restlessness, may make it impossible for the patient to take his food, and artificial feeding may be necessary to keep him alive. The physical symptoms associated with severe toxaemia are present, and complete the clinical picture.

The illness lasts from three to ten days, and usually terminates in recovery, although death from exhaustion may occur.

The chronic type of mental illness arising from organic causes shows great diversity in its symptomatology.

In General Paralysis of the Insane, which may be taken as a fairly typical example of this form of mental illness, the symptoms in the initial stages of the disease may resemble any of the functional psychoses. Thus, states of excitement and of depression similar to the two phases of the manic-depressive psychosis, commonly occur. Usually, however, symptoms arising from irritation and destruction of brain tissue are also present. These are: lack of concentration, lapses of memory, enfeeblement of the mental powers, childishness, and gross disorder of conduct out of keeping with the patient's character. The presence of these symptoms, even in the absence of physical signs or symptoms, suggests that the illness is organic rather than functional in character.

In many cases the illness takes the form of a steadily advancing dementia.

A middle-aged man begins to make mistakes in his work. He becomes careless and indifferent. His character shows a certain change. Formerly polite and considerate, he becomes boorish and careless of his social obligations. He loses pride in his personal appearance, and his finer feelings are blunted. He shows little

concern about his disabilities, and his attitude is one of indifference and apathy.

Not infrequently, some outrageous act completely at variance with the patient's character and social position—such as a criminal offence—is the first thing that draws attention to the presence of a serious mental illness. The theft of some valueless article, with no attempt at concealment, is a fairly common symptom in the early stages of the disease. The patient's failure of judgment in business matters may bring about his financial ruin. Alcoholic excess and sexual promiscuity in a person hitherto temperate and of good moral character, may mark the early stages of the disease.

If untreated, the disease makes rapid progress in the direction of bodily and mental enfeeblement. The disorder of memory, which was at first confined to occasional lapses, now becomes well marked. Comprehension is greatly impaired. Any task calling for judgment and intelligence cannot be performed, or, if performed, is done incorrectly. The patient's social habits deteriorate. His powers of judgment and self-criticism disappear. The emotional state may be one of dull apathy or the patient may show a depressed state with delusions of sin of the most extravagant kind.

The delusions of grandeur, which are popularly regarded as characteristic of this type of mental illness, appear in states of excitement and emotional exaltation. The enfeeblement of the patient's critical faculties is clearly indicated by the utterly impossible character of the delusions he expresses.

In association with the mental symptoms, characteristic physical symptoms occur. These are inequality of pupils, irregularities in their outline, failure of the pupils to contract when stimulated by light, while the reaction to accommodation is retained: tremors of the tongue and limbs, apoplectic and epileptiform seizures, slurring, indistinct speech, and loss of control of the bladder and the bowel. The patient's writing is tremulous and illegible.

In the terminal stages of the disease, he is a physical and mental wreck, and death occurs in untreated cases in from two to five years.

Even in untreated cases, however, remissions of several months' duration may occur. The mental disability in the organic type of mental disease varies greatly in intensity, and is fairly closely related to the amount of destruction of brain tissue present. In many cases the organic changes are progressive and end in death, but in

a considerable number of the organic psychoses the progress of the disease may be arrested at any stage, though in these cases where there has been an appreciable destruction of brain tissue, the restoration of mental function is rarely complete.

In Korsakov's psychosis, which is a form of organic psychosis usually caused by chronic alcoholic poisoning, the memory defect, which is the characteristic symptom of the psychosis, may persist, although the other symptoms disappear. This memory defect takes the form of inability to retain new impressions, so that a patient whose conduct is superficially normal and whose personality is well preserved, may be unable to remember what takes place around him from hour to hour. In most cases the memory defect does not exist alone, for it is usually accompanied by some degree of dementia. There are cases, however, in which the symptoms other than memory defect are very unobtrusive.

In certain organic psychoses the intellect and memory are relatively unaffected while the moral sentiments are grossly perverted. This is characteristic of morphinism, cocaineism and certain forms of alcoholism. In these cases, however, it is doubtful whether the moral degeneration is the result of the specific effect of the drug on the brain. It is more likely a manifestation of the character of the drug addict. In chronic alcoholism the impairment in the patient's memory and intellect is no doubt due to the destructive changes in the brain, but the character changes are to be regarded as a distortion and exaggeration of inherent personality traits.

The criminal offences which may be associated with the organic psychoses are numerous and diverse, but they have usually certain common characteristics which arise directly from the nature of the mental symptoms of the disease. They bear the mark of the lack of intelligence, the confusion of mind, the loss of memory and the general deterioration of intellect and character which is characteristic of these types of illness. The offences are usually unpremeditated. In their execution they show gross lack of judgment and intelligence on the part of the perpetrator, and often the offence is completely out of keeping with the patient's normal character and social position. Thus, the general paralytic patient steals an article worth a few shillings, without any attempt at concealment. Under the influence of the delusion that he is a multi-millionaire, he orders several Rolls Royce cars.

Offences against the person vary in gravity from assault to rape or murder.

In arteriosclerotic brain disease, persecutory delusions of a transient character, accompanied by explosive outbursts of rage, are not uncommon symptoms, and in this state of mind the patient may commit assaults of a minor or serious character. These outbreaks of violence are, however, usually directed against members of the patient's family or household, so that as a rule they do not lead to criminal prosecution.

The loss of memory which occurs in the senile psychoses frequently leads the patient unwittingly to commit offences. It is characteristic of this condition that the patient's social behaviour may remain fairly correct, although the power of retention is grossly impaired, so that a senile psychotic woman may continue nominally in charge of her household affairs long after her illness has rendered her unfit to discharge her duties. The result may be that she forgets to carry out some legal obligation; for instance, she forgets all about the lighting regulations and omits to draw the curtains.

Sexual offences in elderly people are frequently symptoms of arteriosclerotic brain disease or senility.

The moral depravity associated with drug addiction has already been mentioned, and in some cases may take the form of sexual crimes and acts of violence, but contraventions of the Dangerous Drug Act are probably the most common form of offence in this type of illness.

The perversities of conduct which occur in children following encephalitis lethargica are well known and may assume any form of delinquency.

States of depression with suicidal impulses may occur in any form of the organic psychoses.

A married man of 44 was charged with indecent exposure. The investigation of his mental condition while in prison awaiting trial led to his removal to a mental hospital.

His history showed that the first apparent symptom of mental illness showed itself a year before his admission to hospital. One evening his mother found him sitting outside the door singing loudly. Although he had the key for the door he told his mother that he was waiting for her arrival because he could not get in. Soon after this he began to show peculiarities in his behaviour. He sang a great deal in bed and rattled his fingers against the wall. He was rarely at home except for his meals. He would come home very tired and perspiring, take his food and hurry out again. One day he left the house at mid-day and returned at seven o'clock. He told his mother that he had

made a long journey. It was later discovered that he had stolen a bicycle and that he had cycled about thirty miles. Some distance from his destination he fell off the bicycle. A policeman came to his assistance and saw him safely on to a bus, which took him home. Next morning on his own initiative he went to the police station to claim the bicycle. Two days later he was arrested for exposing himself in an indecent manner in the street.

A formal mental examination did not reveal any gross deterioration of his intellect or his memory. He was correctly orientated and he was able to give a good account of himself.

His mood was one of mild elation and he was abnormally unconcerned about his position. In the ward he behaved in a mischievous, foolish manner.

Physical signs and symptoms of general paralysis were not prominent, but laboratory tests confirmed the diagnosis, and later, in spite of treatment, the patient became progressively demented.

The following case shows very clearly the type of behaviour disturbance which occurs in general paralysis.

A man of 43 years of age, whose mental condition had been causing concern to his family over a period of three years, was admitted to a mental hospital in 1939.

The patient, who was a banker by profession, was employed in 1935, as a bookkeeper to a firm of lawyers. He had always been conscientious in his work and punctual in his habits, but one day he failed to appear in the office, and when his books were examined it was found that the sum of £1000 was missing. The money was never traced, but the patient's family made good the loss to the firm. For four days the patient was missing, and then he was found peering into his house through the glass door.

After his return home he had a period of unconsciousness lasting for two days. He began to make foolish, lying statements. He would tell his brother, with convincing detail, that there was every likelihood that he would get a very remunerative post, whereas, in reality, he had no grounds for thinking this, and although he applied for numerous posts he was never successful in getting one. He became careless in his personal appearance, and unconventional in his social behaviour. When visitors came to the house he would sometimes suddenly announce at six o'clock in the evening that it was time to go to bed and he would leave the room and go to his bedroom. He set out from home to attend a lecture, which had already been given, and on his return home he told a circumstantial story of having seen the lecturer, who had already left the town.

He was brought to see a consulting psychiatrist. After he left the

consultant's house, a silver cigarette box full of cigarettes was missing. Next day, in the mental hospital to which the patient had been admitted, the silver cigarette case was found in his possession. He left it lying open on the dressing-table in his bedroom, and he had already distributed most of the cigarettes to the other patients in the ward. When the owner of the cigarette case claimed his property under the patient's eyes, the latter showed no embarrassment, nor did he offer any explanation.

Laboratory tests confirmed the diagnosis of general paralysis. The patient was unsuccessfully treated by malaria, and he died of his condition two years after his admission to hospital.

EPILEPSY

Epilepsy is not a specific clinical entity but a group of diseases of which the common features are recurring convulsions or disturbances of consciousness. It is therefore preferable to speak of "the epilepsies" rather than of epilepsy and to reserve the term epilepsy for idiopathic epilepsy, a condition of obscure etiology for which so far no physical cause has been discovered. Although many theories have been put forward to account for the disease none has won universal acceptance and the cause of the condition is unknown. Idiopathic epilepsy usually shows itself in childhood or in adolescence, and although the symptoms may vary greatly in their intensity and in the extent to which they interfere with the life of the patient the condition is in most cases progressive and incurable. The recurring attacks which form the distinctive features of the disease assume two forms: the major attack or grand mal and the minor or petit mal attack.

In a typical major epileptic attack there is a sudden and complete loss of consciousness, which is immediately followed by a tonic spasm of the entire skeletal musculature. Breathing is obstructed by the spasm of the throat muscles. The patient's face becomes cyanosed. This stage, which only lasts a few seconds, is followed by the clonic phase of the paroxysm in which violent jerking movements of the muscles occur. The convulsive movements continue for a few seconds and then cease. There follows a state of coma, in which the patient lies as if asleep. When consciousness is regained there is usually some degree of mental confusion. This may be so slight and of such short duration that almost immediately the fit is over the patient may be able to get up and continue whatever he was doing before the fit. States of

automatism may follow the fit. These are of medico-legal importance, because in such states of altered consciousness the patient may commit criminal acts of which he has afterwards no memory.

In the minor attack a convulsion does not occur, and the attack takes the form of a momentary disturbance of consciousness. There is a sudden pause in the patient's activities, his gaze becomes fixed, and his movements are arrested, so that if he is taking a meal the fork may stop on the way to his mouth. When the attack is over he may assume his previous actions as if nothing had happened, but in some instances normal consciousness is not completely attained, and the patient's relations with his environment may continue to be imperfect for a considerable period. During this period actions are performed of which the patient has no recollection after he has regained his normal state. In this automatic state he may perform a stereotyped action, such as the removal of his collar and tie, he may undress himself completely, or he may urinate in public. Violent attacks upon bystanders may be committed in these automatic states.

The frequency of the paroxysms in epilepsy vary greatly in the individual case. The fits may only occur at intervals of months or years, or several fits may occur in one day. Sometimes the fits follow each other in rapid succession without any interval between each fit. In such a state of status epilepticus the patient may die of exhaustion.

The mental symptoms associated with epilepsy may vary between a slight change in the personality and a state of profound dementia. Epilepsy is associated with certain personality traits of a distinctive kind, which constitute the so-called epileptic character. This epileptic character may sometimes show itself before the fits begin. Sensitiveness and egocentricity are usually described as the salient features of the epileptic character and certainly in many cases these character traits are well marked. The epileptic is usually profoundly interested in himself. He is insatiable in his demand for notice and attention. He demands redress for trivial worries and inconveniences. He has an acute awareness of the shortcomings of others, but he is blind to the faults in his own character. He is childish and sentimental in his emotional attachments. His conversation is often sententious and stereotyped. He shows a childish anxiety to please those whom he likes and on whom he has come to rely to satisfy his demands, which are not infrequently unreasonable. He responds to praise, but he will not

tolerate criticism. He is easily hurt and insulted, and if one is to maintain good relations with him he must be constantly humoured. Some epileptics, but by no means all, are untruthful, irritable, spiteful and quarrelsome.

Epilepsy is not incompatible with continued mental vigour, but in many cases there is well marked mental enfeeblement which takes the form of impairment of memory, inability to concentrate, and a general slowing up of mental activity. The speech is slow and monotonous, and the patient has sometimes difficulty in finding words with which to express himself.

East suggests that the role of epilepsy in the causation of crime has been exaggerated. He quotes a series of cases of 8731 male prisoners, in which only 39, or $\cdot 4$ per cent. were considered to be general epileptics by the Prison Medical Officers under whose care they were. In the case of 760 female prisoners 5, or $\cdot 6$ per cent. were epileptics.

The crimes of the epileptics may be divided into two types, those which are carried out in a state of clear consciousness, and those committed in states of epileptic automatism. I doubt, however, whether it is possible to make a clear distinction between these two types in all cases, but there is no doubt that the offences carried out in states of epileptic automatism have very special characteristics. They often take the form of a habitual act, or a caricature of a habitual act: when the patient regains normal consciousness he has no memory of what occurred in the state of automatism. The offence lacks adequate motive, and no attempt at concealment is made.

In a state of altered consciousness, such offences as indecent behaviour, breach of the peace, and crimes of violence varying in gravity from minor assault to rape or murder may be carried out.

Where there is a history of epilepsy and in cases where the offence has the characteristic features already described there is little difficulty in relating the crime to the disease, but epileptics, like other people, may commit offences in states of clear consciousness, and in these cases there may have been a difference of opinion on the question of the accused's responsibility. In every case of epilepsy there is some mental disturbance which permeates the whole personality, and we cannot see how any act committed by an epileptic can be completely dissociated from his disease, and we would be inclined to regard an epileptic who commits a serious offence as insane and not responsible for his act.

A man of 23 years of age was charged in 1934 with the crime of rape.

His history showed that he developed symptoms of epilepsy when he was 8 years of age, and he was under treatment for a year in an epileptic colony.

He had a fairly good scholastic record, but during his latter years at school his conduct was undisciplined and he neglected his work. As he grew up his behaviour became more and more abnormal. In his home he was irritable and quarrelsome. If his whims were not humoured he would fly into a violent temper, in which he abused his mother and swore. This form of behaviour was in marked contrast to his attitude to his mother at other times, when he was most affectionate and considerate to her. He spent money recklessly. His behaviour in business showed lack of judgment and shrewdness. He was described by his father as vain and boastful. He was very untruthful. He sometimes related stories of successful business deals, which often turned out to be grossly exaggerated or quite untrue.

In prison, while waiting trial, the accused was irritable and quarrelsome. His mood alternated between states of despair in which he gave in to maudlin weeping, threw himself to the ground and threatened to commit suicide, and states of violent rage in which he uttered ferocious threats against the warders. While he was in prison he was observed to take epileptic fits.

When he was examined he was found to be clear in his mind. There was no gross impairment of his intellect or his memory. He looked somewhat drowsy and he talked in a slow, monotonous voice. Once or twice during the interview he seemed to become slightly confused for a few moments. At these times there would be a pause in his conversation and the patient explained that during these attacks he experienced an acute sense of mental fatigue and an inability to recollect events in their proper sequence. At times during the interview he became slightly emotional, but on the whole, his behaviour was not grossly abnormal. He was able to give a clear and connected narrative of the events which occurred on the day when the crime was committed and he was able to say how the offence occurred.

When the case came into court a plea of insanity in bar of trial was put forward. The plea was sustained and the patient was sentenced to be detained during His Majesty's Pleasure.

In this case there was no question of the offence having been committed while the accused was in a state of post epileptic automatism, but there is no doubt that it was a manifestation of his disease, which taken along with the other symptoms of gross mental disorder which he showed, constituted adequate grounds for regarding him as an insane person.

In embarking on a discussion of criminal responsibility in mental disease, one is very conscious of one's inability to make any new contribution to a subject which has already been so exhaustively treated by so many writers in the past, and one can hardly hope to do more than review and comment upon some of the views of other writers contained in the voluminous literature on this very controversial subject.

The use of words and phrases in medical and legal writings, which are capable of more than one interpretation, has been a serious cause of confusion of thought and of misunderstanding between lawyers and doctors. Such terms, for instance, as insane, mental disease, and unsoundness of mind are incapable of exact definition, and may be used in more than one sense.

The term insanity is often used wrongly to mean mental disease. Insanity is not a clinical entity. "Insane" is not so much a medical term as a legal designation of a person who, because of mental disease, is socially or legally incapacitated. Strictly speaking, perhaps the term should only be used of a person who has been certified insane, but it can also be used in the sense that the person's mental abnormality is of such a character that it is possible to certify him insane.

When a psychosis is well developed, the patient's conduct is usually so disordered that it is either necessary or possible to certify him insane, but the existence of a psychosis in a person does not necessarily imply that he is insane in the sense that it is either possible or desirable to certify him. States of mild depression occur which are undoubtedly manifestations of the manic-depressive psychoses in which the only manifestations of the disease are lack of buoyancy, a slight feeling of malaise, a difficulty in making decisions, and a lack of self confidence. Such a condition is often not regarded either by the patient or his relatives as a mental illness, but as a slight physical indisposition. It would be quite impossible and unnecessary to certify the patient insane: yet he is suffering from a psychosis. The presence of a psychosis then, does not necessarily imply insanity.

It must be admitted, however, that even medical men sometimes use the term insane and insanity in a clinical sense. The psychoses are sometimes referred to as "the insanities" to differentiate them from the milder forms of mental illness, the neuroses, and one is apt to speak of degrees of "insanity" as when we say, speaking loosely, that one patient is more insane than

another. The term should be used in the restricted sense I have described, that is, in the sense that a person either has been certified as insane, or is capable of being certified.

The term unsoundness of mind is, I think, usually used as equivalent to insanity, but this must be regarded as a technical use of the term, because obviously unsoundness of mind may mean any departure from the normal standards of mental health.

Mental illness and mental disease usually signify insanity to the lay person, but such an interpretation is entirely erroneous, for these terms are used to describe any disability of psychic function which involves discomfort or incapacity to the patient. The only obvious symptoms of mental illness may be a disturbance of the bodily organs. Thus, hysteria—which is a mental illness—may take the form of a functional paralysis of a limb.

Mental illness may be regarded as an attempt on the part of the patient to relieve internal tension arising from conflict between instinctive drives. "In the last resort, most psychic disorders may be traced back to disturbance in the equilibrium of love and hate." (Glover.) The symptoms are the devices used to deal with the psychic situation as it exists from moment to moment, and their character depends upon the pattern of the particular mind with which we are dealing.

There is no sharp dividing line between normal and abnormal mental functioning. In mental disease the essential stuff of the mind is not changed. Nothing new is added to it, and everything arises from material already there. The difference between normal and abnormal mental functioning is quantitative, not qualitative. The devices, or mental mechanism, which in mental disease operate to produce symptoms, are also used extensively by the normal mind. There is thus no fundamental difference in character between minor forms of mental illness in which the question of a person's sanity does not arise, and in the psychotic disorders where the affected person is frequently insane. Indeed, one can go further and say that the psychotic's symptoms, which make it possible for a person to be certified insane, are, in many instances, a distortion and exaggeration of mental processes which occur in the so-called normal mind. Nevertheless, the quantitative difference between mental functioning in the normal mind and mental functioning as it occurs in the person suffering from a psychotic illness, is very great, and it is this difference which is responsible for the gross changes in the patient's personality and

in his conduct, which are characteristic symptoms of the psychotic types of mental illness.

It is frequently a deviation from normal behaviour which attracts attention to the existence of mental illness, but while the fact that a person has been accepted as normal by his friends and associates, is strong presumptive evidence of the absence of gross mental disorder, such evidence is not a proof that the patient is of sound mind, for in many instances, a person may continue to behave correctly in his social relations long after his mind has become severely disturbed; for instance, the delusions of the paranoiac may be present for months and years before their existence becomes apparent by a change in the patient's behaviour.

In many instances, the conduct of a mentally disordered person is modified by his nature, his education, and his ethical and social training. A man who is naturally aggressive will tend to show his aggressiveness in an exaggerated form when his mind becomes disordered. On the other hand, a person whose conduct is guided by a strict code of morals, is less likely to commit anti-social acts under the influence of mental disorder than a person of lower moral standards. There are, however, many exceptions to this generalisation, and conduct in psychotic illness depends a great deal upon the type of illness. In some types of illness one finds that there is a complete reversal of the patient's previous personality and his standards of conduct. *Even the mildest psychotic illness influences the total personality and exerts some influence upon the patient's thinking and his behaviour.* The mind does not function, either in health or disease, in parts, but as a whole. Therefore, it follows that when a person suffering from a mental illness commits a criminal act, it is wrong to assume his conduct was uninfluenced by his illness, because the act, in itself, does not seem to be irrational, but appears to have been brought about by such motives as self interest or revenge which often dictate the conduct of a normal person. On the other hand, there are few cases of mental disease, except cases of advanced dementia, in which the patient is so completely dominated by his symptoms that he is uninfluenced in his behaviour by motives such as self esteem, fear of consequences, social sentiments, and a sense of duty, which regulate the behaviour of normal persons.

In considering the motives determining the conduct of an insane person who commits an offence, we cannot assess with accuracy the relative influence of abnormal and normal processes in the

motivation of his conduct, and the only safe rule is to assume that his offence could not be entirely uninfluenced by his abnormal state of mind.

One of the distinguishing features of psychotic mental illness is that it frequently deprives the patient of the ability to modify his conduct to meet social situations. Yet, although many psychotic patients appear to be completely detached from their environment, one finds many cases, even of patients who are grossly disordered and whose conduct seems completely uncontrolled, in which the patient can respond as a normal person does to the demands of the particular situation in which he finds himself.

Thus, a woman who is suffering from mania, behaves in a most extravagant way while in the ward with other patients. She is rarely at rest. Her conversation, which never stops, is rambling and disjointed. She is mischievous, and her conduct is a source of serious annoyance to everyone around her. While she is in the ward, nothing will restrain her disorderly behaviour, but this same woman behaves with almost perfect propriety when her relatives take her for a drive, or when she is asked to appear before a class of students.

On the other hand, many patients who are comparatively orderly in their behaviour in the sheltered atmosphere of an institution, would behave in an embarrassing and even dangerous manner in ordinary social surroundings.

It would be quite erroneous, however, to attribute the alteration in the behaviour of either type of patient to deliberate conscious intention. In each case the patient responds to a particular situation in a characteristic way by a process of unconscious adaptation. An insane person who might otherwise commit an offence, might certainly refrain from doing so because a policeman is looking on; but he does so, not necessarily because he has deliberately considered the situation and has decided that if he commits the offence he will be arrested and punished. The fear of the consequence of his act may, in many cases, influence the conduct of an insane person, but it is just as likely that in refraining from committing an offence, he has acted without reflection and deliberation. His behaviour, like that of the patient I have mentioned, is an unconscious response to the situation existing at the time. In the absence of the policeman, he might commit the offence, but the presence of the policeman adds a new factor to the situation, and the person responds automatically to it.

It is not the application of restraint or the fear of punishment which determines the orderly behaviour of patients in an institution who would behave in a disorderly manner in other circumstances, it is rather that the general atmosphere acts upon the patient without his conscious awareness, and influences his conduct. When greater demands are made upon his powers of social adaptability, as, for instance, in his own home, internal mental tension is increased and finds expression in disordered conduct and perhaps in anti-social acts.

Anyone attempting to discuss or criticise the criterion of responsibility laid down in the McNaghten rules which are at present accepted as the law on the subject, is faced with the almost insuperable difficulty of deciding upon the precise meaning of the terms used in the definitions of the rules. The most important passage in the rules is the one which states "that to establish a defence on the ground of insanity, it must be clearly proved that at the time of committing the act, the accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong."

What, for instance, is the exact meaning of the term—"wrong"—as used in the definition?

If we adopt Lord Brougham's interpretation which he gave in the debate in the House of Lords, in 1843, following the McNaghten trial, "that there is only one kind of right and wrong: the right is when you act according to the law, and the wrong is when you break it," then we must agree with Lord Bramwell, who said in his evidence before the Select Committee on the Homicidal Law Amendment Bill, June, 1874, "that the present law lays down such a definition of madness that nobody is hardly ever really mad enough to be within it."

But other legal authorities have interpreted the word "wrong" in a much wider sense than did Lord Bramwell.

Mr. Justice Stephen, at the trial of David Davies at the Glamorganshire Spring Assizes, in 1888, was reported in his charge to the jury to have said:

"It is said that, according to the law, a man is responsible for his acts when he knows that the act is wrong, and that is true. Now, medical men frequently say that many persons who are really mad, do know that the act is wrong. If you will exercise your judgment in the matter, you will probably see that, knowing

the act is wrong, means nothing, more or less, than the power of thinking about it as a sane man would think about it; the power of attaining to a full conception of the horrible guilt there would be in murder; the power of knowing you are doing that which will destroy life and your soul and cause sorrow and terror and every kind of frightful consequence; the power of thinking about all this, that power which every sane man possesses.

"That is the law, as I understand it, which by guilt implies the power of discriminating between right and wrong; that is the test of responsibility."

Then, going on to speak of the accused, he said:

"You have heard this poor man's condition described. How could he know whether the act was right or wrong? In a fit of epilepsy, he could not. He would not know what he was doing, would not know anything at all about it. He would do it as a matter of course, just as in a physical convulsion, he would throw his arms violently about."

Again, at the trial of William Burt, at the Norwich Assizes, on the 9th November, 1885, Mr. Justice Stephen, is reported as having said that:

"If a man were in a state of passionate rage, excited by disease, which violently interfered with his actions so that he had not a fair capacity to weigh what he was doing or to know that his act was wrong, he was not responsible."

He instructed the jury that they had not to consider whether a man had a particular disease, but whether his conduct was in itself sane, whether he acted from ordinary wicked motives, or under the influence of disease. If a man acted partly from a common motive and partly from a disease, he, the judge, suggested that it was for a humane jury to give the man the benefit of the doubt, and take into consideration whether they would not have him taken care of instead of subjecting him to punishment. If there was epileptic fury and insanity mixing with ordinary resentment and causeless jealousy, and a man acted from both motives, his lordship thought the general spirit of the law and its administration suggested that the prisoner should have the benefit of any doubt which arose.

It only requires a superficial knowledge of mental disease to realise that a large group of insane offenders, who would be held responsible if Lord Brougham's interpretation of the word "wrong" is used, will be regarded as not responsible if the word

“wrong” means “the power of attaining a full conception of the act” as suggested by Mr. Justice Stephen.

This group of insane, but responsible offenders will include most offenders suffering from manic-depressive psychoses, all the paranoiacs, many cases of schizophrenia, and indeed, the majority of insane criminals.

One of the phrases used in the McNaghten rules to describe the offender's knowledge of the criminal act, is “to know the nature and quality of the act”, but it is also stated that if the accused was conscious that “the act was one he ought not to do and if the act was, at the same time, contrary to the law of the land”, he is punishable.

Surely it is not the same to say that a man knew that what he was doing was wrong, as to say that he knew the act was one he ought not to do?

A melancholic woman may know that by killing her child she is doing wrong, but if she thinks that by killing the child she is saving it from some terrible fate, would it not be correct to say that she is convinced that the act is one which she ought to do? Although she knows that the act is contrary to the law, and punishable, she feels obliged to commit it. In other words, she feels that the act is one she ought to do.

The McNaghten rules have frequently been criticised on the grounds that they are based on obsolete theories on mental disease. To this criticism the defenders of the rules retort that the questions at issue are matters of law which do not come within the province of medicine. In their Report, the 1924 Committee on Insanity and Crime use this argument to refute the criticisms of the Rules contained in the memorandum of the Royal Medico-Psychological Association which was presented to them. The Committee's Report states:

“It may be that the judges who framed the rules took into consideration the medical view as to the nature of insanity generally accepted in 1843, if there was one. But it is certain that they were not professing to define ‘disease of the mind’ but only to define what degree of disease of the mind negatived criminality: as much a question of law as the question at what age a child becomes criminally responsible. . . . When once it is appreciated that the question is a legal question, and that the present law is that a person of unsound mind may be criminally responsible, the criticism based upon a supposed clash between legal and medical

conceptions of insanity disappears. It is not that the law has ignorantly invaded the realm of medicine, but that medicine, with perfectly correct motives, enters the realm of law."

But if the tests of insanity are matters of law, it is difficult to see why medical experts are asked to testify. "If," as the American lawyer, Judge Doe, said, "the tests of insanity are matters of law, the practice of allowing experts to testify what they are should be discontinued; if they are matters of fact, the judge should no longer testify without being sworn as a witness and showing himself qualified to testify as an expert."

A person's capacity to know that what he is doing is wrong, is a mental process—a process which cannot exist apart from his mind. Therefore, the validity of an opinion on the ability of a person to know wrong, depends upon whether the opinion is based on a true conception of mind, and its characteristics in health and in disease. If the conception of the mind, upon which the opinion is based is erroneous, it is at least highly improbable that the opinion will have any validity.

Now, our knowledge of the mind and of mental disease is very imperfect. Much is unknown, and indeed, from the very nature of mind, it is doubtful whether complete knowledge of it and its working is possible, but while we cannot formulate accurate and precise laws about mental processes, we can say, in the light of modern knowledge, that the mind is not as it was conceived to be by the legislators responsible for the McNaghten rules. The mind upon whose capacity to know wrong a medical man is asked to express an opinion, is not a real mind, but an artefact, an ingenious invention of the judges who made the rules.

If a motor engineer called as an expert witness in a case is asked his opinion about the behaviour of a motor car in certain real or hypothetical circumstances, he would have every right to expect that the vehicle he is dealing with is a motor car as he knows it. He would find great difficulty in expressing an opinion if the judge insisted that the motor car with which the law is concerned is one which runs on rails and is yet able to move freely from one side of the street to the other, and one whose behaviour is in no wise affected when its steering mechanism is out of action!

It is impossible for the doctor and the lawyer to reach agreement on the question of criminal responsibility while they approach the matter from a totally different standpoint, as they still do.

The law deals with an individual who is capable of clear cut

conceptions of right and wrong—an individual whose actions are guided by logic and reason, but this individual in whom reason reigns supreme, is, in reality, an imaginary person. The real person with whom the physician has to deal when he comes to assess responsibility, is only partially guided by reason in his conduct. His actions, like many of the actions of the normal person, spring from the unconscious mind which knows nothing of reason and logic, which is self-contradictory, and which is dominated by impulses which seek gratification, often regardless of the dictates of reality. The person whose mind functions according to the lawyer's psychology reminds one of Charles Lamb's Scotsman, of whom he says:

“His understanding is always at its meridian—you never see the first dawn, the early streaks. He has no falterings or self-suspicions: surmises, guesses, misgivings, half-intentions, semiconsciousnesses, partial illuminations, dim instincts, embryo conceptions, have no place in his brain or vocabulary. The twilight of dubiety never falls on him. Between the affirmative and the negative there is no borderline with him. He cannot compromise, or understand middle actions. There can be but right and wrong.”

The real person with whom the physician has to deal is more like the youthful Gargantua, who we are told, “Sharpened his teeth with a top, washing his hands with his broth, and combed his head with a bowl. He would sit betwixt two stools, would cover himself with a wet sack and drink in eating his soup. He did eat his cake sometimes without bread, and bite in laughing, and laugh in biting, and hide himself in the water for fear of rain. He would strike out of the cold iron, would beat the dogs before the lion, put the plough before the ox, would beat the bushes without catching the birds, thought the moon was made of green cheese and that bladders were lanterns, and of his fist would make a mallet. He always looked a given horse in the mouth, leapt from the cock to the ass, and put one ripe between two green. By robbing Peter he paid Paul. He kept the moon from the wolves and hoped to catch larks if ever the Heavens should fall.”

Although the McNaghten rules have been so roughly handled in criticism by lawyers and doctors, it had never been possible to find a satisfactory alternative to them.

In its memorandum to the 1924 Committee on Insanity and Crime, the Royal Medico-Psychological Association of Great Britain and Ireland suggest:

- (1) The legal criteria of responsibility expressed in the Rules in McNaghten's case should be abrogated, and the responsibility of a prisoner should be left as a question of fact to be determined by the jury on the merits of the particular case.
- (2) In every trial in which the prisoner's mental condition is in issue, the Judge should direct the jury to answer the following questions:
 - (a) Did the prisoner commit the act alleged?
 - (b) If he did, was he at the time insane?
 - (c) If he was insane, has it nevertheless been proved to the satisfaction of the jury that his crime was unrelated to his mental disorder?

The memorialists draw attention to the practice in the Scottish Courts, and point out that: "By Scots Law, as by the Law of England, insanity is a good defence only in so far as it negatives the existence of *mens rea*, and the Rules in McNaghten's case were for some time quoted with approval by judges as expressing the law of Scotland no less than that of England, . . . but they do not now appear to be considered in Scotland."

We agree that this is the practice in the Scottish Courts to ignore the McNaghten rules, and since the memorialists appear to approve of it, it is surprising that they suggest that it is not sufficient in order that a person may be absolved from responsibility that he should be found to be insane. They also suggest that if he is insane, the jury should consider whether it has been proved to them that his crime was unrelated to his mental disorder. We agree most wholeheartedly that if there is any doubt about the accused's *insanity* that the question whether the offence was related to the *mental disease* which exists should be considered. Henry Maudsley, writing in 1876, predicting the changes in the law of criminal responsibility which might be made in the future, suggests that the question which will probably be submitted to the jury will be substantially—"Was the act the offspring or produce of mental disease?" It is not clear, however, whether Maudsley meant mental disease amounting to insanity, or merely mental disease in the medical sense of the term.

The Royal Medico-Psychological Association memorialists, however, make it clear that they do not consider insanity in itself sufficient answer to the charge, for the jury may be asked to con-

sider whether the crime was unrelated to the mental disorder even in cases in which they are satisfied that the accused is insane.

The present writer holds the opinion strongly that if the jury are satisfied that the accused is insane, they should not be asked to consider whether his crime was unrelated to his mental state. If a person is insane he should not be regarded as responsible for his offence.

This opinion has been expressed by legal authorities. Lord Kenyon, in his summing up in the trial of James Hadfield for high treason in June, 1800, is reported to have said:

“With regard to the law, as it is laid down, there can be no doubt on earth. To be sure, if a man is in a deranged state of mind at the time, he is not criminally answerable for his acts, but the material part of the case is whether at the very time the act was committed, the man’s mind was insane.”

The Scottish law on the subject was expressed by Lord Justice-Clerk Inglis, in 1863, in the following terms:

“In a strictly legal sense, there is no insane criminal. Concede insanity and the homicidal act is not criminal. The act of the insane, which in the sane would be criminal, lacks every element of crime.”

It is true that insane is not a precise term, and that probably every medical man has his own criterion of what constitutes insanity, but nevertheless, this difficulty need not concern us because in this particular matter, we are not dealing with cases in which the person’s insanity is in doubt, but in cases in which the jury is satisfied that the person is insane, and it is my strong opinion that if a person’s abnormality is of such a degree that the consensus of medical opinion regard him as insane, he should not be held responsible. Further, I do not believe that in any case where the mental disease amounts to insanity, it is possible to say that the offence was unrelated to the existing mental disease.

In actual practice in the Scottish Courts, the question of the accused’s responsibility rarely becomes a matter for consideration when the existence of insanity at the time of his trial is undisputed.

In Scotland a plea of insanity may be put forward either in bar of trial, or in bar of sentence.

It is only in cases where all the medical experts who have examined the accused are agreed that he is insane that the plea of insanity is put forward in bar of trial. The medical evidence is

usually heard by the judge without a jury, and if he is satisfied that the accused's insanity has been established, he will order him to be confined during His Majesty's Pleasure.

If an accused person who has been found insane and unfit to plead recovers from his mental disorder, he could no doubt be asked to stand his trial, and at his trial the question of his state of mind when the crime was committed would be investigated, but in practice it must be very rare in Scotland for a person who has been found insane and unfit to plead to be asked to stand his trial after he has recovered his sanity.

In cases where there is a conflict of medical opinion regarding the accused's mental state, the plea of insanity is put forward in bar of sentence, and in these cases the jury, after hearing the evidence, decide whether the accused was or was not insane when the offence was committed.

The fact that the doctrine of partial responsibility has been introduced into Scottish law makes it obligatory on the jury, when the case is one of murder, and where medical reports on the accused's mental state have been put forward, to decide not only whether the accused was insane when he committed the act, but whether if he was not insane, he was in such a state of mental derangement, short of insanity, that his responsibility is lessened, so that the crime is reduced from murder to culpable homicide.

The attitude of the law of Scotland on partial responsibility was stated as follows by Lord Alness in the case of John Henry Savage, who, in May, 1923, was charged with murder. In his direction to the jury, Lord Alness said:

"If you are satisfied upon the evidence that he did (kill Grier-son), you will then proceed to consider the second question, which is, Has the prisoner proved to your satisfaction that he was insane at the time? But a third question remains behind these two, and it is this, Even if the prisoner has not proved that he was insane at the time, has he proved that his mental condition was such as to reduce his crime from the crime of murder to the crime of culpable homicide, which varies in degree? You will have to say whether the state of mind of the prisoner at the time, while not amounting to insanity, was such as to render appropriate, and indeed proper and necessary, a verdict of culpable homicide rather than of murder.

"Now, that there may be such a state of mind of a person, short of actual insanity, as may reduce the quality of his act from

murder to culpable homicide is, so far as I can judge from the cases cited to me, an established doctrine in the law of Scotland. It is a comparatively recent doctrine, and, as has at least twice been said from the Bench to a jury, it must be applied with care. Formerly there were only two classes of prisoner—those who were completely responsible and those who were completely irresponsible. Our law has now come to recognise in murder cases a third class, the class which I have described, namely, those who, while they may not merit the description of being insane, are nevertheless in such a condition as to reduce the quality of their act from murder to culpable homicide. Now, ladies and gentlemen of the jury, let us distinguish here. To say that a man who takes drink, and while under its influence commits a crime, is to be excused from the penalty of crime merely because he made himself drunk would, of course, be a most perilous doctrine. And it is not the law of Scotland. The man himself is responsible for getting drunk, and the mere fact that he has taken drink, and while under its influence committed a crime, is not sufficient to excuse him from the consequence of his crime. On the other hand, it appears, as I say, equally well established, although it has been variously phrased, that the state of mind of the prisoner may be such, short of insanity, as to reduce the quality of his act from murder to culpable homicide. It is very difficult to put it in a phrase, but it has been put in this way; that there must be aberration or weakness of mind: that there must be some form of mental unsoundness; that there must be a state of mind which is bordering on, though not amounting to, insanity; that there must be a mind so affected that responsibility is diminished from full responsibility to partial responsibility—in other words, the prisoner in question must be only partially accountable for his actions.”

Psychiatrists and criminologists have criticised the existing law with regard to criminal responsibility on the grounds that the law is concerned only with the crime and not with the offender.

“If we examine into the method of criminal procedure we will note that, so far as possible, the individual as such is eliminated and only the act given consideration. Thus, the statute defines certain crimes by stating the act which constitutes them, and in the indictment the offender is charged with doing certain things. It is the crime and not the criminal that is given first consideration.”—(White.)

It seems to the writer that the law of Scotland in introducing

the doctrine of partial responsibility has gone some way to meet this criticism.

Henderson and Gillespie commenting on the doctrine of partial responsibility, say:

"The above rule opens the door very wide, indeed—some think too wide—because, in many cases, an investigation of the accused's life history discloses evidence of extenuating circumstances which indirectly may have had a bearing on the crime."

If a person who has shown symptoms of mental derangement commits a grave criminal act, such as murder, or serious assault, the criminal act, taken with the other symptoms of mental abnormality present, may constitute the conclusive proof of the person's insanity. A person may show eccentricities of conduct which are really symptoms of mental illness, over a long period, but these peculiarities did not render him incapable of living under ordinary social conditions, but if such a person commits a serious crime a medical man would be inclined to relate the crime to the mental abnormality present before the offence was committed. He would regard the crime as a mental symptom of such gravity that he would feel justified in expressing the opinion that the accused is insane, although he would not have expressed this opinion if the offence had not been committed.

It is, therefore, clear that in these particular cases it is essential that if justice is to be done, and if the accused is to be dealt with in the proper manner that it should be proved, beyond dispute, whether the accused did or did not commit the offence.

The writer is entirely in agreement with the views expressed in this connection in the Medico-Psychological Association's memorandum already referred to. The memorialists point out that as the law stands a finding of insanity upon arraignment may result in a man—conceivably unconnected with and innocent of the offence with which he is charged—being ordered to be detained during His Majesty's Pleasure and sent to a criminal lunatic asylum. The memorialists recommend that: "When a person is found unfit to plead, we would suggest that a plea of not guilty should be recorded by the Court, and the trial on the facts allowed to proceed in his absence if he cannot properly be present in Court, arrangements being made for him to be represented by counsel and solicitor. We presume that to enable this course to be adopted some amendment of the Criminal Lunatics Act, 1800 (39 & 40 Geo. III, c. 94), Sec. 2, would be necessary."

The following case is relevant to this part of the discussion:

A man of 37 years of age was charged in February, 1942, at the High Court in Glasgow, with the crime of murder.

The accused was a feeble-minded person who was almost completely deaf and whose articulation was very imperfect, so that his only means of communication with others was by lip-reading and gesture, but even by these means he was able to carry on a conversation only with people whom he knew well.

He had been to school, but on account of his disabilities he had acquired little knowledge there. For fifteen years he worked as a labourer in a brickwork, but on account of physical ill health, he gave up this work and for two years before his arrest he was unemployed.

He lived in a house by himself. He did his own housework and looked after himself in every way. His brother said that the accused was very clean in his habits; that he kept his house in a spotless condition. He was able to buy food and clothing for himself, and he went about freely without supervision. Since he became unemployed he spent most of his time visiting friends and neighbours. He went to the cinema frequently. He was generally regarded as being good natured and kindly. He liked children and he was always very gentle and kind with them.

When he was examined in prison his appearance and his behaviour at first sight suggested that he was an imbecile, but a review of his history and a closer examination of him showed that his intelligence was better than his appearance suggested. He was clear in his mind, and his memory was good. He could write his own name and the names of members of his family. He could do very simple arithmetical calculations. He knew the value of coins.

Owing to his deafness and his difficulty in lip-reading it was very difficult to convey ideas to him or to ascertain his thoughts. While he could be made to understand simple direct questions dealing with concrete matters, it was difficult to convey a proposition to him, and it was impossible to make him understand anything in the nature of an abstract idea. He was, however, able to convey to the examiner by words and gestures that his detention in prison was connected with the death of a certain man whom he named, but it was doubtful whether he realised that he was accused of causing this man's death or that he might have to stand trial. He had some realisation of right and wrong. He knew that criminal offences are punishable, but his whole conception of these matters were those of a child.

He was friendly and amiable in a childish way. He seemed to have little or no understanding of his position, and his one desire seemed to be to get home to the comforts of his own house.

At his trial six medical men gave evidence. They all agreed that the accused was a feeble-minded person, and that the combination of his mental deficiency and his deafness would make it extremely difficult for him to instruct his defence. They were not, however, prepared to say that he was insane or unfit to plead.

After hearing the medical evidence the judge decided to interrogate the accused in the judge's room with his counsel and interpreter. As a result of his interrogation the judge decided that he was insane and unfit to plead, but in view of the unusual and difficult character of the case, he decided to adjourn the trial. The case was considered by five judges of the High Court of Justiciary, who decided that the prisoner should stand trial and that the question of his sanity should be left to be determined by the jury.

The accused was tried at a later date when the medical evidence which had been placed before the judge at his first trial was again submitted to the Court.

The accused was acquitted of the charge.

In this case I cannot but believe that the medical experts were uninfluenced in the opinion they gave by the fact that the accused emphatically denied that he had committed the offence. If it had been clear to them that the offence had been committed, I think there is little doubt that they would have regarded the accused as insane. He was mentally defective and emotionally unstable, but he had done nothing to show that he was unfit to live his own life under ordinary social conditions. Had he committed the offence with which he was charged, it would undoubtedly have been regarded by the medical experts as arising out of his abnormal state of mind, and as conclusive proof of the necessity for regarding him as an insane person.

As we have seen, the accused was acquitted of the charge, and thus the refusal of the medical men to regard him as insane and unfit to plead saved him from the hardship and injustice of being detained in a criminal lunatic institution during His Majesty's Pleasure.

It has always been the contention of medical men that there are many cases in which an offender is insane and also irresponsible, in which it cannot be said of him that he did not know the nature of the act or that it was wrong. The 1924 Committee admit that there are such cases, and that the McNaghten formula is not logically sufficient to deal with them. In order that such cases may be absolved from responsibility, the Committee recommend that it should be recognised that a person charged criminally with an

offence is irresponsible for his act when the act is committed under an impulse which the accused "was by mental disease, in substance, deprived of any power to resist".

When can an act be said to have been carried out under an uncontrollable impulse? No doubt the answer to this question will depend upon whether it is based on the deterministic or the free will theories of action.

The libertarian would no doubt say that an act which is carried out under an uncontrollable impulse is one which is not willed by the person who does it, but is on the contrary, imposed upon him by some force which the will cannot resist.

To the determinist, however, on final analysis, an act carried out under an uncontrollable impulse is not very different from any other kind of act. To say that an act was carried out under an uncontrollable impulse to him means only that the act was carried out because no psychic or physical event occurred to prevent it, and this can be said of any act once it has been done, for in any action involving conflict, if the impulse or drive responsible for the act had not been irresistible, the act would not have been done.

Perhaps, however, by uncontrollable impulse is meant any impulse which could not be controlled except by the application of physical restraint. There are acts of this nature. An act carried out by a person in a state of acute mania in which the excitement amounts to frenzy or an act carried out in a state of delirium, might well be termed an uncontrollable act, for in such states of profound mental disorder, the person affected acts blindly without appreciation of his surroundings and without apprehension of what he is doing. Similarly, the sudden meaningless acts of a schizophrenic patient may legitimately be regarded as uncontrollable acts, but such acts as these, when they are of a criminal character, already come within the McNaghten rules, for every mental expert would unhesitatingly say that the accused, in such cases, did not know the nature of the act or that it was wrong, and that he is therefore not responsible for it. It is not, however, such cases as I have mentioned that the Committee had in mind when they proposed the introduction of the rule of uncontrollable impulse. They suggest that the rule would be applicable to cases of mothers who are seized with the impulse to cut the throats, or otherwise destroy their children to whom they are normally devoted.

Mothers who yield to impulses to murder their children usually

do so because they are suffering from melancholia, and to introduce the doctrine of uncontrollable impulse in order to ensure that a melancholic woman who kills her child shall not be held responsible for her act, seems to us nonsensical, for in such cases the act lacks the essential character of a criminal act, because there is no intention on the part of the person committing it to do wrong. Moreover, it is open to argument whether a melancholic mother kills her child as a result of an uncontrollable impulse. If by uncontrollable impulse is meant an impulse which no power, short of physical force, can restrain, then it can be said, without hesitation, that this is not the kind of impulse which, in many instances, causes a melancholic to commit murder. The truth is that homicidal acts by melancholic patients frequently show evidence of premeditation and careful planning. Indeed, the act may appear to be more deliberate and more carefully executed than many criminal acts carried out by persons who are apparently free from mental disease. Moreover, there is every reason to believe that, in many cases, the melancholic's morbid impulses can be controlled by the same circumstances which act as inhibiting agents in the conduct of sane criminals. It must be very unusual for a melancholic patient to kill her child in the presence of a third person who would interfere and prevent her carrying out the act. If the melancholic is driven to murder her child by an uncontrollable impulse, presumably by the same reasoning, suicidal acts which occur frequently in cases of melancholia can be explained in the same way, but if this were true, every melancholic patient in a mental hospital known to have suicidal impulses would require mechanical restraint to prevent them committing the act. In practice we find that such a degree of restraint is very rarely necessary. Constant supervision is essential, and this alone is sufficient in almost every case to prevent the patient even attempting to commit suicide. Now whether the melancholic patient refrains from attempting suicide because she knows that the nurses in attendance upon her will interfere and frustrate her purpose, or whether the mere presence of the nurses brings about a change in the patient's mind, which for the time being abolishes or lessens the desire to commit suicide, one cannot say, but whichever way it happens, it seems that the patient has been able to resist the impulse.

If we believe that a free will governs the conduct, we are driven to the conclusion that the melancholic patient who refrains from

committing suicide because of the presence of a nurse at the other end of the ward, has done so from the exercise of a free choice. If she is capable of free choice in this matter, then she cannot be dominated by an uncontrollable impulse. It might be suggested, however, that in these cases in which the melancholic patient refrains from suicide or homicide in the presence of a person who might restrain the attempt, the impulse is not uncontrollable, and that it is only in cases where the patient does attempt the act that the impulse is uncontrollable. The carrying out of the act in these cases is the proof that the impulse was uncontrollable. But could not the same reasoning be applied to explain the criminal acts of a sane person, as for instance, the housebreaker who waits until the policeman has disappeared round the corner before he breaks into the house? Could it not be said that the presence of the policeman enables the housebreaker to refrain from the act, but that when the policeman was out of sight the impulse to commit the act proved too strong and became uncontrollable? It may be argued, however, that the mental state of the housebreaker is entirely different from that of the melancholic woman's in that in the one case the person is presumably free from mental illness, whereas the other is insane, and further, that the housebreaker has no desire to refrain from committing his act, whereas the melancholic patient is the victim of conflicting desires: one, impelling her to commit the act, and another working to restrain the morbid impulse.

It is probably true that, in most instances, the sane criminal is not troubled by scruples of conscience. No restraining impulse enters his consciousness, and it is also probably true that the melancholic patient feels that her desire to commit suicide or to murder her children, is something foreign to herself: something imposed upon her.

It is doubtful whether these distinctions between the behaviour of the insane offender and the sane criminal exist in all cases, but if we assume, for the sake of argument, that they do, the conclusion to which we are driven is that while the sane offender's conduct is rational (it is very doubtful whether it is in actuality) the melancholic patient's conduct is not. In the one case, the act is the product, or appears to be the product, of a sound mind, and in the other, it is a product of an unsound mind, and this is the only absolute distinction we can make between the act in the one case and in the other.

The members of the Committee were alive to "the difficulty of distinguishing some of these cases from cases where there is no mental disease, such as criminal acts of violence or sexual offences where the impulse at the time is actually not merely uncontrolled, but uncontrollable", but they suggest that the rule postulates the existence of mental disease in the cases to which it is applicable, and that this would serve to distinguish these cases from the other type of case where the act is uncontrollable, but in which mental disease is absent.

It will be noticed that the Committee wish to distinguish not between cases where there is insanity and cases where there is no insanity, but cases in which there is mental disease and cases in which there is no mental disease.

As we have already said, the term mental disease and the term insanity are not synonymous. It is quite true that insanity is a term which it is impossible to define with precision, but compared with the term mental disease which may be used to describe conditions as different as a mild anxiety state and advanced General Paralysis of the Insane, insanity is almost a specific entity.

If the term mental disease, as used in the Report, means mental abnormality and not mental disease amounting to insanity, what would happen if a person suffering from mild anxiety—from which few persons are free—commits an offence, and in his defence pleads that the offence was done under an uncontrollable impulse?

Such an offender might truthfully be said to be suffering from mental disease, and if he asserts that he experienced an uncontrollable impulse to which he was forced to yield, who is prepared to deny that it was the mental abnormality from which he is suffering that deprived him of the power to resist the impulse? It could hardly have been the intention of the Committee to introduce a rule which would enable offenders suffering from mild forms of mental illness to plead irresponsibility for their acts, for they state specifically that "a person may be of unsound mind and yet be criminally responsible".

But even if we assume that the term "mental disease" as used in the Report means not merely mental abnormality, but insanity, would the introduction of the rule regarding uncontrollable impulse not result in every insane offender whose insanity did not comply with the McNaghten rules being excused under the new rule? It is very doubtful, however, whether it was the inten-

tion of the Committee that the proposed rule should have this result.

If we could make an absolute distinction between mental health and mental disease, and if we could say that every criminal act committed by a person suffering from mental disease has a characteristic, or characteristics, which are absent in every criminal act committed by a person who is free from mental disease, then we would be able to make a rule regarding responsibility which would be capable of universal application. We cannot, however, make such a perfect rule, and any rule that we make can only be capable of limited application. The McNaghten rules are very imperfect, but perhaps their merit lies in their very imperfection, for if a rule is so nearly perfect that it is capable of being applied in the majority of cases, the tendency will be to apply it rigorously to all cases, and this will result in an injustice in those cases in which the rule is inapplicable; whereas if the rule is recognised to be a bad rule, there will be no hesitation in discarding it in those cases which do not come within its scope. The tendency will be for each case to be dealt with on its merits, and when we are dealing with such an imponderable subject as human behaviour, this is perhaps the safest course to adopt.

We agree with those who suggest that the only logical solution to the problem of criminal responsibility is to abolish the legal concept of responsibility and to regard everyone, whether sane or insane, who commits an offence as responsible, but not necessarily punishable, but this question leads to a consideration of matters which are outside the scope of the present discussion.

CONCLUSIONS

The criterion of criminal responsibility laid down by the law is artificial, and inapplicable in many cases, but it is capable of such wide interpretation, and the law is administered in such a liberal and humane manner, that no injustice results. Therefore, provided it is not regarded as objectionable that the attainment of the purpose of the law should be dependent on the use of expedients which have the effect of rendering the stated law nugatory, amendment of the existing law is not an urgent necessity.

It is impossible without introducing a fundamental change in the attitude of society to crime and responsibility to formulate a test of criminal responsibility which will serve in all cases.

The recommendations, already quoted, contained in the memorandum submitted by the Royal Medico-Psychological Association of Great Britain and Ireland to the Committee on Insanity and Crime, if adopted, would probably be the most satisfactory solution possible without a complete reorientation to the entire problem of crime and punishment, but we suggest that the third question to be addressed to the jury which in the Report reads, "If he was insane, has it nevertheless been proved to the satisfaction of the jury that his crime was unrelated to his mental disorder?" should be amended to read, "If he was *not* insane, has it nevertheless been proved to the satisfaction of the jury that his crime was unrelated to his mental disorder?"

The introduction of a rule to enable an accused person to plead irresponsibility on the grounds that his offence was committed under an uncontrollable impulse, which he was by mental disease in substance deprived of any power to resist, is undesirable and unnecessary.

III

PSYCHONEUROSIS AND CRIMINAL BEHAVIOUR

By DR. R. D. GILLESPIE

THE relationship of the conditions known as psychoneuroses to crime is still a debatable one. As Karpman said only a few years ago, "it is a field of work in which only a bare beginning has been made."

One of the difficulties is of a practical kind. Those whose work is primarily medical have seen many psychoneurotic conditions, while medical criminologists tend to see only a few psychoneurotic individuals among the criminal population. Thus of 4,000 male delinquents examined by W. Norwood East only 24 were regarded as having a psychoneurosis or, more correctly, as displaying a psychoneurotic reaction. It is evident from such figures that a connection between psychoneurosis and crime cannot be presumed but requires demonstration in an individual case to show whether such a connection exists at all. Moreover, even among the 24 cases mentioned by East, hysteria was the most frequent psychoneurosis, and it will be seen subsequently that general deductions about the connection between psychoneurotic symptoms and crime cannot be made immediately from an association between crime and hysterical symptoms.

Unfortunately it is also true that because of the relatively unexplored nature of this field of enquiry there are considerable differences of opinion among the medical psychologists who have had access to criminal populations on a large scale; thus Karpman, in apparent opposition to East's opinion, believes that the majority of criminal actions have a psychoneurotic basis.

It becomes very necessary therefore to define as well as possible what is meant by psychoneurosis, and to see how far an analysis of criminal activity will support the thesis that crime is at least in some cases the outcome of a mental illness of a psychoneurotic type.

MEANING OF PSYCHONEUROSIS

1. *Descriptive.*—The term psychoneurosis has from the standpoint of classification two connotations, of which the second in-

cludes the first. In the first and historical connotation the popular meaning of psychoneurosis is purely descriptive. It is a term referring to conditions characterised by certain mental and physical symptoms and signs, occurring in various combinations. The most usual of these combinations or syndromes have been distinguished as sub-types of psychoneurosis called respectively neurasthenia, anxiety psychoneurosis, hysteria, and obsessional or obsessive-compulsive psychoneurosis. None of these is dependent on the existence of any discoverable physical disease. They are not mutually exclusive categories so far as symptoms are concerned, but they signify certain recurrent patterns of symptoms commonly occurring together. The commonest symptoms of neurasthenia are fatigue, mental and physical, poor sleep, headache, weakness and defective memory—more correctly, the patient *thinks* his memory is defective, but put to the test no failure of memory can be demonstrated.

Of an anxiety psychoneurosis the commonest physical symptoms are palpitation, breathlessness, indigestion, headache, pains anywhere, and insomnia, in fact, the symptoms of disturbance of any organ by emotion. Everyone knows that if one is frightened one's knees shake—the origin of these symptoms is very similar.

The mental symptoms of an anxiety psychoneurosis are principally morbid fears, and these morbid fears may be of disease, that is, of some internal danger, or of some external situation not in itself dangerous, such as going out alone. Some depression of spirits is frequent.

The symptoms of hysteria include aches and pains and insomnia and various physical disabilities which seem to indicate actual loss of function rather than the mere disturbance of function that characterises an anxiety psychoneurosis. In hysteria there may be paralysis of any part of the body, including the organs of speech; there may be loss of one of the special senses—thus the patient may be apparently blind or deaf or part of his body surface may be anaesthetic; while sometimes there is a localised excess of function in the form of tremors and “tics”, which are habitual repetitive movements of some group of muscles such as produce head nodding. Convulsions used to be commoner in hysteria than they are now, for reasons lying outside this discussion. The most characteristic feature of hysteria, however, is the mental attitude, which is apparently one of calm imperturbability. The hysteric characteristically protests that he is not worried or anxious or

mentally distressed. He may, however, complain of complete loss of memory for certain periods of his life, and he may be reported as having indulged in a fugue. In a fugue the individual wanders away from his normal habitat in an apparently irresponsible fashion to some quarter where he has no apparent business or aim; afterwards he has no apparent memory for this eccentric occurrence. The extension and elaboration of such an episode with a return at intervals to the normal mode of existence constitutes a "multiple personality". In this condition there may be a complicated and well-organised existence distinct in its characteristics from the patient's normal life and interrupting the latter at intervals, with apparent failure of the individual to remember the abnormal episodes when he is in his ordinary state.

The use of the term "hysteria" is unfortunately confused. Hysteria in the vulgar sense means little more than uncontrolled emotionalism, which is not at all the medical sense of the word. Medically the term hysteria may refer either (*a*) to a collection of symptoms, or (*b*) to a type of psychological causation, but sometimes it means (*c*) a type of personality characterised by immaturity, self centredness, dramatic display and a habitual tendency to exploit situations for selfish ends. In literature one of the best descriptions of this type of personality is found in Lord David Cecil's picture of Lady Caroline Lamb in *The Young Melbourne*. A separate term is needed here. "Histrionic personality" is more descriptive, while "hysterical psychopath" is perhaps more scientific, since "psychopath" emphasises a constitutional rather than a purely psychological basis for such personality.

The fourth traditional symptomatic type of psychoneurosis is the obsessional or obsessive-compulsive. The symptoms and signs here can also be either physical or mental or both, but a distinguishing feature is the sense the patient has that the symptom is forced upon him; an obsessive thought obtrudes itself against his will and leads even to a compulsive action which he feels obliged to carry out and the execution of which may give him some temporary relief. Neither the obsessive thought nor the compulsive action may affect the conduct of everyday life. The patient recognises their abnormality, even their absurdity, and tries to resist their obtrusion on his consciousness. Morbid fears are also frequent in this condition, of which likewise the patient recognises the absurdity. Examples of obsessive thoughts are the idea that he may have killed someone, or the recurrence of some obscene phase. An example

of morbid fears is the fear that if he sees a knife he may use it upon the first person he encounters. As an example of compulsive action we have the historic instance of Dr. Johnson of whom it is recorded that he had to tap each post in the Strand as he passed it; he was probably a victim of this malady. The distinguishing feature of this psychoneurosis is a hyper-conscientiousness in certain matters, such as excessive neatness and tidyness in dress, but this is not incompatible with socially reprehensible acts such as sexual misdemeanours, which may have nothing compulsive about them. People with this syndrome, however, have seldom if ever been known to put their obsessive thoughts into action when these have been of an anti-social nature, such as the thought and fear of killing some one. In a series of 50 cases A. Lewis did not find one such instance in which a compulsive impulse had been put into execution, but he alludes to one case from the literature. Norwood East (*Medical Aspects of Crime*, 1936) describes what he believes to have been an example of a criminal action with a compulsive basis.

2. *Etiological*.—These are the symptomatic implications of psychoneurosis. It has, however, another connotation, more fundamental, since it is an etiological one. This is to the effect that psychoneurotic symptoms are an indication of mental conflict. The following definition attempts to be both comprehensive and at the same time exclusive of other types of mental illness where mental conflicts may also play a part, but where the symptoms are determined as to their particular form by constitutional factors of a special kind. (*Psychological Effects of War*, p. 39.)

Psychoneurotic reactions (Psychoneurosis) are abnormal mental states exhibiting either mental or bodily symptoms and signs, or all of these, which are the result of persistent mental conflict in personal relationships, past or present in regard to others or to oneself, and which are susceptible of cure by psychological means, the patient retaining the same view of the real world as the ordinary man; whereas in the types of reaction called psychotic the world is viewed in the light of delusional or hallucinatory experience, of disorder of thought, or of profound disturbances of feeling.

The existence of mental conflict is the reason for the existence of psychoneurotic symptoms; but because the individual is unconscious either of the conflict within him, or at least of its connection with his symptoms, the psychoneurotic symptoms appear

in the ordinary sense to be irrational. Although they may consist for the most part of ideas, no rational explanation exists for them in terms of the rest of the patient's thoughts so far as he is able to give an account of them; or if the mental conflict expresses itself as physical disturbances, such as blindness or paralysis or tremor, no physical disease can be found that can be regarded as causal. A psychoneurotic patient may be disconcerted by a morbid fear of travelling in a train or a bus, or he may be unable to go more than a few yards from his own door, but he does not have the faintest notion why; yet this fear may be so impelling that the attempt to walk a few yards in the open may prove utterly beyond him.

The irrationality is confined, however, to the account that he is able to give of his symptoms. If enough of his thoughts and feelings are known, what has seemed mysterious becomes logical and coherent with the rest of the contents of his mind. It has been demonstrated many times that there are undercurrents of feeling and thought, and connections between thoughts and feeling, which the individual himself may be quite unaware of until the connection is exhibited to him. This roughly is what is meant by "unconscious" mental processes, *i.e.* processes not of a physiological but of a psychological order, of which the subject is unaware.

Since there is still a reluctance to concede the existence of certain types of unconscious mental process, largely because of the nature of some that have been revealed by psychological investigation, and since there is a difficulty in conceiving how processes of a mental order can be unconscious, it is perhaps necessary to illustrate the existence of such mental processes from more ordinary life. Everyone will agree that we are all influenced in our opinions by experiences of which for the time being we take no cognisance. For example, we are more likely to vote Conservative at an election if we have property and more likely to vote Labour if we have none, although in both cases we will very stoutly deny being actuated by any selfish consideration. The individual, in other words, is unaware that these considerations decide his vote, and he may even deny that they exist at all. When this happens, he may be said to repress them—to be unconscious of them. A distinction is made between what is unconscious simply because it is not necessary to think of it at the time (such, for example, is one's knowledge of farming when one is playing bridge) and the

repressed unconscious thought or feeling which is unconscious because it is kept out of a consciousness for some reason or other, usually a motive connected with egotism, or with conscience itself. These repressed unconscious entities may be thoughts and feelings referring only to contemporary situations, or they may be what might be called archaic, that is to say, thoughts and feelings originating in a much earlier period of life, even in infancy. For example, to continue the original analogy—a young man may vote socialist apparently because he is a reformer and idealist, but actually because his father was Conservative in his politics, and because he had developed an antagonism to his father in early childhood which had never been fundamentally eradicated or resolved, so that the young man tends to violate the paternal expectations even when the relationships between them in adult life are apparently good. His socialist vote is an indication of an old rebellion repressed at the time in favour of social conformity with the family.

Neurotic behaviour may likewise result from conflicts arising between inclinations and wishes, either contemporary or archaic, on the one hand and social requirements on the other. Conscience in this respect is but a mental precipitate of the individual's perception of social demands. A neurotic symptom is a compromise of some sort between the unexpressed thoughts and the repressive forces, these repressive forces being mainly conscience and self regard (egotism); hence conscience frequently has an archaic aspect and a psychoneurosis often reaches extreme intensity of development, partly because of the intensity of these primitive feelings which have contributed to its formation.

The psychoneurotic symptom is not, however, to be conceived as a mere resultant or by-product of opposing mental tendencies; it is not merely the smoke from a fire. It is apt to have a function, by being useful in some way to the individual in whose mind it is generated, although he is commonly quite unaware that its usefulness, if any, is more than incidental. It may be useful in a material way, for example, a headache may furnish an excuse from duty; or, in a fantastic way, as when a compulsive act helps to ward off some danger against society, such as a wish to injure or even to kill some one who may have meant much to the individual in the past. Some compulsions are but the perpetuation by force of habit of a defence against such wishes entertained originally in the nursery, or not much later.

MODES OF GENESIS AND FUNCTIONS OF PSYCHO-
NEUROTIC SYMPTOMS

It is necessary for our present purpose to envisage the various ways in which a neurotic symptom may be produced and what are the functions it performs, and then to show if possible by examples how unlawful acts (using unlawful to include criminal and delinquent) may have a precisely similar genesis and serve similar purposes.

Symptoms Serving as an Escape.

The simplest type of genesis of a psychoneurotic symptom is found in the contemporary field in the conflict between the socially originated sense of duty and the individual's inborn desire to escape danger in time of war. If the wish to escape be very strong as the result of inborn or acquired timidity (the way in which this timidity may be acquired is a psychological problem in itself) or if the sense of duty or social conscience, which in these cases is the repressing force, is relatively weak, whether from inadequate upbringing and moral preparation, or from fatigue, then instead of complete control of the desire to escape there arises a state of mental tension or of unstable equilibrium between the two tendencies. Such tension may cause bodily disturbances to develop which thrust themselves on the patient's attention. In the case of a foot soldier this is more apt to take the form of palpitation or muscular weakness, both of which can be the direct effect of emotional tension acting on the physical organism. In the case of an airman the underlying fear may, by the classical mental process of projection, be attributed to some property of the aeroplane, so that instead of complaining of some physical disorder in himself he declares that a particular machine is not trustworthy. These symptoms, whether they be palpitation or distrust of a machine, if they are sufficiently intense may so preoccupy the patient as to disable him from duty. In this way he achieves escape from the duty of facing the enemy. The purpose of the symptom, a purpose of which the subject is quite unconscious, is thus fulfilled. It should be observed that the individual constantly denies that he is afraid; he ignores or "represses" this fact, thus saving his self-esteem. Lest this state of affairs be regarded as synonymous with cowardice it should be said that such symptoms may arise in people with much war experience but whose ability to act accord-

ing to their social conscience and to resist the natural instinct of self preservation has been weakened by fatigue.

It is not perhaps very difficult for the uninitiated to conceive such mental processes as have just been described, for they refer to contemporary matters and they involve widely known and understandable human tendencies. But much of the resistance to modern psychological science outside the ranks of its professors has arisen from two circumstances; the first that the earlier discoveries were made in regard to the sexual instinct, a subject hedged around with taboos and prejudice; and secondly, that the raw material was derived from early childhood and from alleged happenings in the infant's mind, which made the acceptance of the psychologist's discoveries much more difficult, both on account of the apparent improbability of the mental processes uncovered, and on account of the difficulty of conceiving how such distant occurrences, even if they were accepted as facts, could have persisted so long into adult life. More recently, however, the psychologists themselves have concerned themselves with mental contents of other sorts—the aggressive and affectionate impulses of childhood—and have found that these are at least as often concerned with the production of mental conflict and psychoneurotic symptoms as anything in the sexual field. A moment's consideration will show that these discoveries are not so improbable as they seem. No one who has had anything to do with children can doubt the existence of aggressive impulses, even of a very crude kind, in them. A charming small girl of five or less may be heard to threaten her doll not simply with spanking, but with such sadistic performances as gouging out its eyes, and she may be found, perhaps at an even earlier age, to have carried out some of her threats by mutilating the inanimate object of her rage. It is one of the interesting discoveries achieved in the domain of treatment through play that in such instances the doll may stand for a real person—it may be father, mother, brother or sister—in the young child's mind. These are distinctly anti-social impulses, and in growing up the child has to learn to school them by the development of conscience and its restraints. But sometimes conscience is not enough to ensure complete control—it may be because of inadequate training or of a particularly strong inborn tendency to be aggressive, but more often because relationships between the parents themselves and between parent and child are faulty. The result is a mental tension developing between conscience and the anti-social impulses

struggling for expression. The child, and later the adult—for these conflicts may persist for many years in the hinterland of the mind—may go as far as to develop a special technique of keeping aggressive impulses under control. For this purpose resort is commonly made to magic, consisting in very much the same manner as among primitive peoples, in the development of a habitual gesture or of some mental formula. These “compulsions”, as they are called, are akin to the superstitious acts which are prevalent in many adults and were originally endowed by the child with magic efficacy in counteracting the evil wishes insufficiently repressed by conscience alone. Such impulses, acting as defences against anti-social tendencies, are compromises in the sense that the underlying impulse produces an act, but an act so modified by conscience that its real intent is unrecognisable either by the subject or by anyone else. In other instances instead of an outward act the individual may develop a fear of the means whereby the anti-social impulse may be carried into effect, such as a fear of knives, the mere presence of which may thereafter disturb the individual.

Symptoms as Defences, as Substitutes and as Self-punishment.

Such symptoms whether compulsions or obsessive fears (phobias) may be regarded as defences and substitutes. This is most clearly seen where the obsession or compulsion arises from contemporary situations in an adult and may be wholly conscious. For example, a young woman came to out-patients with a persistent lesion of the skin of the left forearm which no medicaments were successful in healing. The lesion was unsightly and persistent. Confidential enquiry, pressed home, produced from the apparently calm and self-possessed young woman a flood of tears and a story of great antagonism to her invalid mother who was monopolising her daughter's entire existence. The sense of frustration rose to such a pitch over the years that her daughter, a conscientious person, began to find herself entertaining lethal thoughts against her mother, which disturbed her very much. Feeling very guilty on the matter, she proceeded to injure herself, thereby carrying out on her own person an act which one side of her would have liked to perpetrate on her mother. This introduces another element in the genesis of symptoms, namely, the tendency to self-punishment. Following this confession the skin lesion healed up and did not recur.

The fate of the affectionate impulses when these are thwarted in childhood has lately also engaged the attention of psychiatrists. An impression of rejected love is found to be a common factor in producing neurotic symptoms. If the child finds or thinks it finds that its parents do not love it, then, since they are presumed by the child at that tender age to be infallible, the child concludes it is unworthy of their love and becomes depressed. This depression of spirits may persist into adult life as a feeling of inferiority, which is one of the most frequent of psychoneurotic symptoms, although this is not its sole origin. Sometimes the circumstances which produce it are very real and obvious, for example, an unkind step parent. At other times the lack of affection is fantasy and not a fact, but the result may be the same.

Symptoms as Compensation and as Revenge.

The feeling of not being loved may lead to other results such as an attempt at compensation for it by seeking overwhelming demonstrations of approval elsewhere—this being a basis of neurotic ambition, or a vengeful attitude may develop. For example, a young woman who had always been neglected by her mother in favour of her more attractive sister, developed an abdominal pain when the latter left home. By means of this she was successful in getting attention from her mother such as she had never before received, and she kept the mother constantly at home attending to her invalid needs, thus attaining a certain amount of revenge for previous neglect. She herself was so persuaded that the pain was of physical origin that she submitted to several useless major operations mistakenly undertaken.

Psychoneurotic symptoms then are the result of conflict between social demands and personal wishes. The conflict may be entirely unconscious, that is to say, that the struggle may go on without the subject being aware that it is taking place. This is more readily appreciable when the symptoms represent the persistence of a conflict which was initiated in childhood and never been resolved. But the capacity of human beings for self deception is so great that even conflicting and contemporary issues, like facing the danger of battle, may be unconscious in the sense that the individual may completely deny having any fear, and apparently with complete conviction. This phenomenon is not confined to those who are new to battle conditions. It may be encountered in those with long meritorious records.

In summary, psychoneurotic symptoms may be dependent as we have seen on a wish to escape from a difficult situation; they may be defensive against socially reprehensible wishes or they may be substitutes for acts repugnant to the conscience; they may represent a punishment, a kind of atonement for thoughts stimulating a feeling of guilt; they may be compensatory for some real or imagined deprivation of affection, or they may represent revenge for the same reasons.

Modes of Genesis and Functions of Criminal Acts.

It can be shown that criminal acts in the broad sense, and more particularly delinquent acts, can originate in what appear to be precisely similar ways. These anti-social acts can thus be regarded as the equivalent of psychoneurotic symptoms. "A delinquent act is founded on the same mechanisms (*sic*) that we regularly find in a neurotic symptom." (Aichhorn.) The relationship between psychoneurosis has been described as follows: "The neurotic is one whose thoughts are criminal but who does not have the courage to commit the crime and in whom the fear of consequence leads to a compromise. . . . Society has won the war but at a great cost to the individual to remain a good moral citizen but at the price of developing a neurosis." (B. Karpman.) Karpman goes on to say that almost every case of habitual crime is the expression of some mental problem, the significance of which was entirely hidden from the conscious horizon. Early privations, jealousy and revenge . . . and a sense of insecurity and "paraphiliac" (perverse) drives are but a few of the many underlying mechanisms.

Such claims may go further than can be accepted as established, but what is brought out is the relationship between crime and psychoneurosis, at least where the psychoneurosis is based on rejected love, hate and anger. The question is, when may anti-social acts in our present state of knowledge be regarded as psychoneurotic symptoms, to be distinguished from crime, which is the *direct* expression of anti-social impulses. To be considered neurotic, (a) they must be the outcome of a conflict. (b) One set of the conflicting forces must be the social conscience although this conscience itself may be an infantile rather than an adult structure. (c) The act must be a compromise and not the direct expression of personal wish for gain for oneself or for injury to society. If it is a direct expression of any such wish it is then a criminal act or an insane one. (d) There must be no material gain,

or if there is it must be possible to show that the apparent gain is not the object of the act, but that the latter has some private meaning derived from special sources in the individual's mind.

Healy, after many years study of delinquent acts has concluded that they may be interpreted as belonging to one of any of the categories already enumerated in the etiology of psychoneurotic symptoms.

A delinquency may represent, according to Healy and Bronner:

“(a) an attempt to avoid, even as a temporary measure, the unpleasant situation by escape or flight from it;

“(b) an attempt to achieve substitutive compensatory satisfactions through delinquent activities;

“(c) an attempt to strengthen or bolster up the ego wounded by feelings of inadequacy or inferiority;

“(d) a delinquency may also represent an attempt to get certain . . . satisfactions through direct and conscious or even unconscious expression of revenge attitudes, perhaps through a hidden desire to punish parents or others by conduct that will make life difficult for them;

“(e) an attempt to gain a maximum of self-satisfaction, to inflate the ego, by generally aggressive, anti-social attitudes;

“(f) a response to instinctual urges felt to be thwarted;

“(g) a wish for punishment which was always a response to a conscious or unconscious sense of guilt.”

One of Healy's cases showed both the escape and the revenge motive very clearly in response to the extreme preference which his father showed for his twin brother. This was a boy of six who had run away from home and from school on numerous occasions. He had stolen from his parents and others and had attempted to set a house on fire. The twin, on the other hand, was a model child. The noticeable thing was the differential attitude of the father towards the delinquent and his twin. The father had taken a sudden dislike to him when he was only two months old, always repelling him when the child attempted to climb on his knee. The delinquent child showed his antagonism to his father very clearly in some of his remarks about stealing money from his teacher “so that his Dad had to pay it back”, and he invented a story in which another boy—“a bad boy he was, got at my Dad and set the house on fire”. There is little doubt that his delinquent behaviour both enabled him to escape from his unhappiness at home and serve as a revenge against his father for his lack of affection.

Some delinquent acts may be a defence against some still less permissible action, and in this sense therefore may become symptoms in that they represent a compromise. In this connection Healy cites another case of a young woman who had stolen hundreds of articles and many small amounts of money, some of which were never used. These thefts occurred spasmodically. At intervals she sometimes worked hard for months to get funds to provide conscience money. She had kept a diary in which she recorded all her struggles to control these outbursts, which were so closely connected with sexual urges as to be fundamentally an expression of a desire for sexual experience, which she felt to be wrong. The original association between sex feeling and stealing had been an incidental one, but thereafter one served for a substitute for the other. After marriage her stealing ceased.

Certain sexual symptoms are found to be neurotic equivalents, sexual perversion being a substitute for normal sex brought about by the action of repression. Homosexuality is sometimes a psychoneurosis of this kind. It has, of course, to be remembered that while the homosexual is not at all responsible for the nature of his inclinations he must be regarded as to some extent responsible for what he does with them. If it is recognised, however, that homosexuality is itself a psychoneurosis in some cases and in others probably a constitutional matter, the judicial attitude with regard to homosexual acts must undergo some modification, more especially when it is recognised that psychoneurotic homosexuality, paradoxical as it may sound, may be the result of the operation of conscience in the earlier period of life. The commonest process according to my observation appears to be this: A boy forms a strong attachment to his mother and into this an erotic component enters. The latter component is repressed as a result of the operation of conscience, which presumably originally includes a mental representation of the father's attitude, especially when he is conceived as a rival for the mother's affection. The feeling of guilt is so strong that all heterosexual interest whatever is repressed. Repression is apt to take this form because no association is permissible between the maternal image and erotic feelings, and so no association is permissible between the latter and women in general. But the sexual impulse remains and has to find some outlet; the usual substitute outlet is often a youth of girlish appearance, this representing the nearest approach permissible by conscience to heterosexual interest. In this way homosexuality is seen as a

symptom resulting from a conflict between social conscience and desires originally infantile. This furnishes a good example of the continued operation into adult life of the effects of unsolved conflict in childhood.

Stealing is often exhibited in childhood as a form of compensation and even of revenge for deprivation of parental love. This is more obvious when the stealing is from the parents themselves in the first place, and where the objects stolen are not turned to any use but simply secreted in some private place. Just as psychoneurotic symptoms are apt to diffuse themselves, so stealing may afterwards be generalised. The child may be quite unaware of the connection between his stealing and the feeling of deprivation; he is trying to take in symbolic form what is denied him in real life.

Homology of Psychoneurotic Symptoms and Criminal Acts.

In summary, as with psychoneurotic symptoms, so with criminal or delinquent acts—they may represent a wish to escape from unhappy situations; they may be defensive; they may be substitute phenomena; they may represent revenge; or they may constitute an attempt at compensation for something else that is felt to be lacking—all in relation to inner feelings rather than directly to contemporary circumstances.

It is possibly true that some criminal acts may, like some neurotic symptoms, be the expression of a desire for punishment, the hypertrophied conscience apparently allowing the act to occur for the sake of the satisfaction obtained by expiation of the deed at the hands of the law. I have known a psychopathic individual commit a crime, and another involve himself in "painful incidents" for this reason, but it is more difficult to find convincing instances of crime which is equivalent in its genesis to a psychoneurotic symptom having punishment as its aim. Some writers like Karpman deny that crime can occur on this basis, pointing out that the over-scrupulous conscience which would seek punishment would also revolt at the suggestion of committing crime for whatever purpose. Aichhorn, however, who is a sympathetic and able observer remarked on "cases in our Institution" (a correctional institution for youths) who did everything "they could to provoke punishment".

Conditions of Crime as a Symptom.

In general, however, it will be seen that parallel with each mode of genesis of a psychoneurotic symptom there is a similar mode of genesis of a criminal act. Both symptom and act may occur as an escape or as a defence, as a compensation or substitute, or as a mode of revenge. In the light of these considerations is it justifiable to regard crime in such instances as a psychoneurotic symptom? First, as has already been emphasised, there must be no real gain, or alternatively the apparent gain in a theft or in some act of delinquency, even perhaps murder, must be capable of being shown not to be the real meaning of the crime for the individual. In the particular case of stealing, in order that there should be no real gain it is necessary that the stolen articles should be intrinsically worthless, having therefore a purely symbolic value, or they must not be put to any material use, but hidden away, magpie like, or they must be restored voluntarily by the delinquent before social pressure has been exerted. Secondly, the criminal or delinquent act must be capable of demonstration as the outcome of conflict, and thirdly, the resultant act must be able to be translated as a substitute or a compromise between the opposing tendencies; fourthly, other psychoneurotic symptoms should be present. Are such theoretical deductions fulfilled on examination of the material that presents itself? The answer appears to be in the affirmative.

Clinical Test of these Theoretical Requirements.

Thus, reporting a series of cases of incendiarism in children, H. Y. Yarnell observed the following characteristics: (1) They set the fires with accompanying day dreams of burning some member of the family who had either withheld his affection from the child or become too serious a rival for the parental love. (2) The fires were made in or around their own homes, causing little damage and being usually put out by the child himself, a sign therefore, as Yarnell points out, that the act was chiefly symbolic. (3) The children showed anxiety and suffered from terrifying dreams at night and terrifying fantasies in the day time. (4) All the children had some mental conflicts.

One of the most striking things about this study was the similarity of the children's thoughts to what is found in Biblical writings. Thus, they felt that anyone bad was doomed to destruction by fire, but that in the end everything became new and perfect

by the purifying effect of fire. They seemed to feel that killing by fire would render the object of their act good, and that he would then be restored to life or "reborn".

It is such congruence as this with age-old forms of thought in the discoveries of psychiatrists about the contents of the minds of their patients that helps to carry conviction to the open-minded layman regarding the soundness of clinical psychiatric observations in general.

All the children had suffered from deprivation of love from parents or their substitutes, and many had lacked even food and security; in fact, what seemed to distinguish them from psychoneurotic children and made them delinquent rather than merely psychoneurotic in the ordinary sense was the intensity of their deprivation.

It is doubtful whether it is logically necessary to insist on the parallel presence of psychoneurotic symptoms in the ordinary sense in coming to the conclusion that the criminal act is to be regarded as in itself a psychoneurotic symptom. In the first place, as was pointed out earlier, the association between psychoneurotic syndromes and criminal acts is a rare one. What is evidently much commoner is the criminal act as the expression of a conflict exactly homologous with the kind of conflict that would produce in other individuals a psychoneurotic symptom.

Ambiguous Significance of Hysterical Signs and Symptoms.

The mere collateral presence of psychoneurotic symptoms is certainly not presumptive of a basis for the criminal act in some conflict; this is particularly to be remembered when hysterical symptoms are present. One meaning of the term hysterical has already been discussed where this applied to a type of personality commonly called "hysterical". Such an individual may commit a crime for reasons of prestige, but this can hardly be interpreted as an outcome of any mental conflict.

It has already been pointed out that there are other meanings of the term hysteria. In one sense it means a certain type of symptom already described; in another it means a particular type of psychological etiology. An instance of this type of psychological development has been given in the genesis of homosexuality. "Hysterical" in this sense means any symptom or attribute of character resulting from a so-called Oedipus complex which has never been resolved. An Oedipus complex is a congeries of highly

emotionally tuned attitudes to the mother, rivalry with the father, and a sense of guilt on account of the latter, and perhaps also on account of repressed incestuous wishes towards the former. This kind of individual is apt to exhibit still another type of "hysterical" personality—weak, dependent on his home, unmarried and prone to develop physical and mental symptoms of the hysterical sort when confronted with any problem which requires independent action.

But symptoms of an hysterical type may occur in yet another association, mainly in the type of person who as the result of perhaps faulty upbringing has developed a poor social conscience and a habit of dodging difficulties. This type of person may develop an amnesia when he has done something for which he is likely to be punished, or a paralysis or other symptom when it is a question of some duty which he wishes to avoid. The origin does not lie here in some inner mental conflict either of remote or contemporary origin, but simply in a desire to escape responsibility. It is unfortunate for the individual who develops similar symptoms or signs with quite a different origin, perhaps on a basis of self-punishment, that this type of origin for hysterical symptoms exists, because it makes similar symptoms or signs suspect of being manifestations of weakness and dodging. This difficulty arises particularly in connection with hysterical amnesias, for there are occasional instances in which mental conflict has been so acute as to produce a forgetfulness that is genuine. This may occur in one of three ways: either the conflict so occupies the individual's mind that he becomes confused and so does not register what goes on around him and consequently he cannot remember afterwards; or an experience may be so shattering, as, for example, in warfare when ghastly sights are encountered that an automatic process of repression sets in as a kind of self-protection; while in a third type of amnesia the repression of incidents is based on shame and self-reproach in a conscientious individual.

Because, therefore, of the very diverse origin of the symptoms and signs symptomatically described as "hysterical" a careful analysis of the causal factors is more than ever necessary before concluding that their presence is indicative of intrapsychic conflict.

The question—what produces a psychoneurotic symptom in one case and a criminal act in another is not easy to answer. It probably has to do with the relative strength of the opposing forces.

We have a hint of this solution in Yarnell's observation that the pyromaniac children had suffered more grievous deprivations of affection and security than psychoneurotic children had commonly suffered.

As Wertham says, the psychology of action is an extremely difficult and little understood subject. What is it that leads in one case to a criminal although symbolic act and in another to an hysterical paralysis or a morbid fear? Wertham recalls a story told of Freud, who, after reading a book by one of his pupils on the analysis of a murder case, remarked—"Now we know everything—except why the murder was actually committed."

In a noteworthy study of an adolescent young man sentenced to life imprisonment for the murder of his mother, Wertham has found it desirable to describe under a new term the mental state that produced the crime; he has called it a "catathymic crisis" in order to signify the process more distinctively and to surmount the difficulty that no actual psychoneurotic symptoms were found. In this case, which bears certain remarkable resemblances to the case of Hamlet, as it presents itself to those who have a psycho-analytic type of approach to such problems, Wertham shows that the ostensible reason that the boy gave for the murder of his mother, namely, the "saving of the family honour", was only the apparent and not the real reason, the latter lying in a complicated series of ideas, beginning in early childhood. Many of these ideas and feelings had been repressed in the course of time, but were still operative underneath the surface and ultimately producing a criminal act.

The father had died when the boy was very young, and the boy had taken his father's place and had developed an intense affection for his mother from an early age. When sex feeling arose he repressed it because of the same kind of association as has already been alluded to in the case of homosexuality. There began to develop also a double attitude towards his mother in that since he had been taught to regard sex as bad and had associated his mother in some way with sex, he came to feel that she was in certain aspects bad too. This notion was reinforced in another direction by his observing her unfaithfulness with various lovers subsequent to his father's death. The environment was poor and crude, and these transgressions were very obvious. In brief, it appeared that the boy's action was not really to "avenge the family honour", as he himself said and believed, but was the outcome of a compli-

cated set of feelings and ideas dating from an early age, and most of them not consciously realised. Love, idealisation, resentment, jealousy, intimate desires stifled at their birth, these and many other ideas and feelings provoked by the peculiar circumstances of his life all played their part. They are, as Wertham shows, very curiously analogous to the tragedy of Hamlet which is really the projection on the stage of the conflicts in Hamlet's mind. The motive power of the crime, in fact, lay in repressed ideas and feelings of early origin which had not only never been resolved but had been stimulated by what he saw and experienced. This analysis of Wertham's illustrates the genesis of even a major crime in psychological conditions which in other individuals lead simply to psychoneurotic symptoms, as we know from the analyses of other patients.

It is only by an intimate knowledge of the life history in this manner that the nature of certain crimes can be explained, although the basis for the release of the idea into action remains conjectural.

Where someone commits an apparently unmotivated murder it is not very satisfactory to label the condition "schizophrenic", as is sometimes done in our law courts, chiefly because no one, not even the ambitious layman, can understand why the crime was committed, and yet at the same time there are none of the usual evidences of mental disease. This process of obtaining an intimate knowledge of the life history is a technical and admittedly sometimes an impossible task. It is certainly not one that can be carried out in the course of one or two examinations such as are usually considered sufficient to establish the presence or absence of mental disease in the ordinary sense. But it appears that if we are to carry the administration of justice to that degree of perfection which must be the aspiration of every would-be citizen of a better world, then we must be prepared to perfect our technique and our institutions.

It seems likely that in this millennium judges and lawyers will have to be equipped with that knowledge of psychology and anthropology which will enable them to appreciate and weigh to some extent the authority, the findings and opinions of medical psychologists, and that the latter themselves will have to devote the same care and attention to the elucidation of motives that they have in the past given to the assessment of symptoms.

Jurists will wonder how they can accept the very esoteric

evidence that psychiatric observation brings. It seems likely that this difficulty will solve itself. The sound type of medical-psychological observation has a way of carrying conviction because it is the most intellectually satisfying explanation of all the features of certain crimes (like the one analysed by Wertham) in which the ordinary account is felt uneasily to be insufficient. Why, for example, should a youth attempt to murder his brother who had saved his life in the previous year, and with whom he had always been on the best of terms? Such questions in the past have had no real answer. The facts are apt to be stretched to the procrustean bed of "schizophrenia" when, in fact, there is no schizophrenia. The disappointed psychiatrist has a sneaking sympathy with the case record thus ill treated; he believes that mental pathology rather than crime is involved, but that a pathology of diseases rather than individuals will no longer work.

There are other criteria for the validity of psychiatric interpretations—the patient's own sense of illumination for one thing, or as C. P. Blacker once put it, the feeling that the explanation somehow "clicks". Another is the improvement in the condition brought about by applying the lesson of the interpretation. A fourth is rarely come by—the confirmation of some important item of the patient's inner story by collateral sources of information about the patient's early life. (R. Dalbiez.) Since it is inner fantasies that matter in the long run more than circumstantial fact in the genesis of psychoneurotic symptoms, the possibilities of independent confirmation are in any event small.

The present state of affairs is unsatisfactory on both sides, and cannot become satisfactory until staffs and institutions of the proper kind are provided for the investigation and treatment of crime, just as they are for the medical treatment of psychoneurotic conditions. Such innovations would not imply that judicial control would be in any way weakened; but it would be applied on a scientific basis rather than a traditional and semi-intuitive one. Suitably applied judicial control is a help to treatment and medical men would not seek to supplant or dispense with the restraints of the law but would actually welcome them.

The time for carrying out observations according to these principles is necessarily so prolonged that it could only be effected in a place of detention that was run on scientific and not merely institutional lines. A staff of research aptitude and ability would be necessary at some central institution in each country for the

study of cases of this sort, but with time the units would be budded off from the parent one and planted elsewhere. "We psychiatrists are very humble in the face of the sound precedents which govern the criminal law, but since criminal law is of necessity confined to the adjudication and the regulation of human conduct it is difficult to see why an infusion of the scientific spirit and technique can do anything but good." (B. Glueck.)

There have not been wanting signs in recent years that judges themselves are inclined to this point of view. It is a challenge to medical psychiatrists to be as lucid as they are scientific and to be as scientific as they may be lucid.

LIST OF REFERENCES

- AICHHORN, A. *Wayward Youth*. London, 1936.
 DALBIEZ, R. *Psychoanalysis*. London, 1941.
 EAST, W. N. *Journal of Mental Science*. 1939. 85, 649.
 EAST, W. N. *The Adolescent Criminal*. London, 1942.
 EAST, W. N.; and HUBERT, W. H. DE B. *Psychological Treatment of Crime*. London, 1939.
 FENICHEL, O. *Outline of Clinical Psychoanalysis*. London, 1934.
 GILLESPIE, R. D. *Psychological Effects of War*. London, 1942.
 GLUECK, B. *Journal of Criminal Psychology*. 1939. 1, 91.
 HEALY, W. *The Individual Delinquent*. Boston, 1915.
 HEALY, W.; and BRONNER, AUGUSTA F. *New Light on Delinquency and its Treatment*. London, 1936.
 HENDERSON, D. K. *Psychopathic States*. New York, 1939.
 HENDERSON, D. K.; and GILLESPIE, R. D. *Textbook of Psychiatry*. 5th edition. London, 1942.
 KARPMAN, B. *Journal of Nervous and Mental Diseases*. 1939. 90, 89.
 KARPMAN, B. *Journal of Psychopathology*. 1940. 1, 187.
 LEWIS, A. *Proceedings of the Royal Society of Medicine*. 1936. 29, 13.
 WERTHAM, F. *Dark Legend*. New York, 1941.
 YARNELL, H. *American Journal of Orthopsychiatry*. 1940. 10, 272.

IV

MENTAL DEFICIENCY AND CRIMINAL BEHAVIOUR

By DR. E. O. LEWIS

DR. C. GORING stated that "defective intelligence is one of the primal sources of crime in this country". This statement is quoted from his voluminous report on "The English Convict", published in 1919. The report contains much valuable statistical data relating to the bodily and mental characteristics of 948 convicts whom Goring had examined systematically and observed carefully in the course of carrying out his duties as a prison medical officer. This statement is one of the chief conclusions based upon these data and therefore should not be put aside lightly. During the twenty years that have elapsed since Goring published his report, much progress has been made in this and other countries in the scientific study of criminals. Does our present knowledge confirm Goring's view?

Whilst the Mental Deficiency Act was passed in 1913, comparatively little headway was made in the administration of the Act until after the great war of 1914-1918. During the last 20 years, the Local Authorities have done much to implement this Act. Mentally defective persons residing in their respective areas have been ascertained¹ and approximately 90,000 of these have been dealt with under the Act; about 50,000 are resident in Certified Institutions; of those in the general community under guardianship (approximately 5,000) and the remainder are under Statutory Supervision. It must be admitted, however, that the administration of those sections of the Act specially applicable to criminals, has been disappointing except in a few large cities such as London and Birmingham where the magistrates, police and prison officials on the one hand, and the Local Authorities and their officers on the other, have cooperated well.

¹ The latest available figure is that for Jan. 1st, 1940. The total number ascertained by Local Authorities in England and Wales at the date was 128,234. The Mental Deficiency Committee Report (1929) gives the estimate of the total number of mental defectives of all ages as 300,000 (approximately 0.8 per cent) of the total population. The figure given by Local Authorities who have made a thorough ascertainment in their areas indicate that the estimate of 300,000 is a conservative one.

In 1904 a Royal Commission was appointed to report upon the care and control of the feeble-minded. Many experts on crime gave evidence before this Commission; a number of the witnesses gave estimates of the percentage of all criminals who were mentally defective or inefficient. The estimates varied considerably. One of the more moderate was that of Dr. Parker Wilson, who stated that not less than 20 per cent. of the prisoners admitted to Pentonville Prison showed signs of mental inefficiency. On the basis of all the evidence placed before the Royal Commission, a conservative estimate of the proportion of mentally defective criminals would be 10 per cent. of the total number. Even this estimate, however, far exceeds the numbers of criminals actually certified as mentally defective since the Act came into force. Dr. Norwood East states that a total of 2,626 criminals in the prisons of England and Wales during the ten year period ending December, 1931, were certified as mentally defective; this number corresponds to 0.42 per cent. of the total number admitted to prisons during this period. Doubtless several factors account for this great disparity; and one of the most fundamental is that even amongst experts there has been much divergence as to what constitutes mental defect.

The Mental Deficiency Act of 1913 contains definitions of various grades and types of mental defect, whilst the amending Act of 1927 has modifications of some of these definitions and adds a definition of the generic condition of "mental defectiveness"¹ These definitions have doubtless served a useful purpose during the initial stages of the administration of these Acts; they have assisted in the standardisation of our conception of mental defect, but their usefulness must obviously be somewhat limited. "Mental defectiveness" is a generic term that comprises a complex group of bodily and mental abnormalities each of which in turn presents a complicated problem to the scientist. It is not surprising that the medical expert who undertakes to determine whether a certain person is mentally defective should feel the need of more scientific guides than these definitions afford.

During the last twenty years the doctors and psychologists in this country who have been chiefly concerned with the administration of the Mental Deficiency Acts have been busy evolving scientific standards and criteria of mental defect. Their progress

¹ The Lunacy Acts (1890) have no definition of a person of unsound mind or of insanity.

with this task has been restricted by the meagreness of relevant facts that such basic sciences as pathology, bio-chemistry, genetics, psychology and sociology have been able to contribute to the understanding of the abnormalities presented by the mentally defective. In spite of this handicap, the comparatively small group of workers in this field of study have been able to evolve standards and criteria of mental defect which have been almost universally adopted in England and Wales. Anyone who wishes to study the relationship between mental deficiency and crime should first become conversant with these standards and criteria, and with the technique of their application.¹ At this point before proceeding to give a brief outline of the standards and criteria, it will be convenient to quote the definitions of "Mental Defectiveness" and of the four types of this defectiveness given in the Mental Deficiency Act of 1927.

"Mental Defectiveness" is a condition of arrested or incomplete development of mind existing before the age of eighteen years whether arising from inherent causes or induced by disease or injury

The following three definitions relate to degrees of mental defect, idiocy being the greatest.

Idiots are persons in whose case there exists mental defectiveness of such a degree that they are unable to guard themselves against common physical dangers.

Imbeciles are persons in whose case there exists mental defectiveness, which, though not amounting to idiocy, is yet so pronounced that they are incapable of managing themselves or their affairs, or, in the case of children, of being taught to do so.

Feeble-minded persons are those in whose case there exists mental defectiveness, which, though not amounting to imbecility, is yet so pronounced that they require care, supervision, and control for their own protection or for the protection of others, or, in the case of children that they appear to be permanently incapable by reason of such defectiveness of receiving proper benefit from the instruction in ordinary schools.²

¹ Prof. C. Burt's *Handbook of Tests* is the manual most commonly used in this country. Detailed discussion of standards and criteria will be found in such text-books as *Mental Deficiency* by Dr. Tredgold and *Mental Deficiency Practice* by Drs. Shrubsall and Williams.

² In the Education Act 1921 Part V., Sect. 55, there is a definition of Mentally Defective Children who come within the jurisdiction of the Local Education Authority. They are defined as those children who not being imbecile, and not being merely dull

The other group of the mentally defective defined in the Acts is that of "Moral Defectives".

Moral Defectives are persons in whose case there exists mental defectiveness coupled with strongly vicious or criminal propensities, and who require care, supervision and control for the protection of others.

The definition of "mental defectiveness" lays stress upon the feature that specially distinguishes the condition from that of insanity. The mental development of a defective person is retarded and incomplete, it never attains maturity; whereas in the case of an insane person the mind has developed normally and, with rare exceptions, reached maturity, but has then become disordered. Mental defect is mental *dwarfness*, whereas insanity is mental *disease*. The other feature of mental defectiveness specified in the definition is that the condition is either congenital or occurs before the individual attains the age of eighteen. Insanity, on the other hand, rarely occurs before the mind attains maturity.

The aetiology of mental defect has been the subject of much controversy. One group of protagonists maintain that in most cases the condition is inherited, whereas the other group think environmental factors are predominant in the causation of mental defect. "Environment" in this context has a wide connotation; in fact, it includes all factors other than heredity that may prove detrimental to the normal development of the individual from the moment the ovum is fertilised.

Without attempting to discuss the relative merits of the arguments put forward by these two groups, an indication of the general trend of scientific opinion on this subject may be given by quoting the results published recently by Dr. L. S. Penrose, who made a thorough investigation of more than a thousand mentally defective patients at the Royal Eastern Counties Institution, Colchester. Penrose came to the conclusion that in 29 per cent. of cases the condition was attributable solely to heredity, whereas in 9 per cent. it was due solely to environmental factors; and in the remaining 62 per cent. both heredity and environment were contributory factors.

In the Mental Deficiency Acts the three degrees of defectiveness are differentiated by criteria of social inefficiency. The idiot

or backward are by reason of mental defect incapable of receiving proper benefit from the instruction in the ordinary public elementary school, but are not incapable by reason of that defect of receiving benefit in special schools or classes.

is unable to guard himself against common physical dangers; the imbecile is incapable of managing himself or his affairs; whilst the feeble-minded person requires care, supervision and control for his own protection or the protection of others. Such criteria are unsatisfactory from a scientific standpoint because they lack precision. The medical expert has turned to the psychologist, and not in vain, for standards by which these three grades of mental defect can be differentiated.

So universal has the application of Standardised Scales of Intelligence become that it is unnecessary to describe in detail their main features or the technique of the examination. Psychologists make the claim, and researches in every civilised country have done much to substantiate it, that with these Scales of Intelligence, a fairly accurate assessment can be made of any person's intelligence. The assessment is made in terms of mental age. Thus, if a man has a mental age of 12, it means that his general intelligence is equivalent to that of a normal child of this age.

For statistical purposes, it is more convenient to express level of intelligence in another form—variously known as "Intelligence Quotient" (I.Q.) or "Mental Ratio" (M.R.). This is arrived at by the following formula:

$$\text{I.Q. or M.R.} = \frac{\text{Mental Age}}{\text{Chronological Age}} \times 100.$$

A child of 12 who has a mental age of 12 will have an I.Q. of 100 per cent., that is, he is quite normal. Another child of this age with a mental age of only 9 has an I.Q. of $\frac{9}{12} \times 100 = 75$ per cent.

An important modification of the formula has to be made when the intelligence quotient of an adult is under consideration. The maximum denominator (chronological age) is 14. Psychologists have come to this conclusion on the basis of much evidence that, speaking generally, the factor which these tests measure—that is general intelligence, reaches maturity when the individual is 14 years of age.¹ Therefore, in order to calculate the intelligence quo-

¹ The proof of this disturbing statement, which most persons when they first hear it strongly resent, is one that cannot be given in detail here. One indication of the reliability of this statement is the fact that when various intelligence tests have been applied to a large representative group of adults, the average score, as well as the general distribution of the scores is no better than that of a representative group of children all 14 years of age. Whilst general intelligence appears to mature about the age of 14, mental development in other respects may continue.

tient of any person who is over 14 years of age, divide his mental age by 14 and multiply by 100. Thus, an adult whose mental age is 9, has an I.Q. of approximately 64 per cent.

The medical expert decides to a great extent to which of the three grades—idiot, imbecile, or feeble-minded—a mentally defective person belongs by determining his mental age. For our present purpose we will confine our remarks to adult defectives, *i.e.* person over 16 years of age. The most authoritative statement on the standards and criteria for differentiating the three grades of mental defect that has been made in this country in recent years is that given in the Report of the Mental Deficiency Committee,¹ appointed by the Board of Control and the Board of Education.

The standards for adult defectives specified in this report may be summarised as follows. An idiot has a mental age below 3; an imbecile a mental age below 6; and a person with a mental age below 9 is almost certain to be feeble-minded. The approximate Intelligence Quotients corresponding to these ages are 20, 40, and 65 per cent. respectively. The Committee made an important proviso concerning the upper limit for feeble-mindedness. Whilst all adults with mental ages below nine are almost certain to be feeble-minded, there are many others with mental ages of 10, 11, and some even of 12 who have been found to be feeble-minded. The diagnosis of mental defect is determined by many factors other than that of mental age or intelligence quotient. The essential criterion of mental defectiveness is *social* inefficiency; and not infrequently inefficiency is due to specific intellectual defects or temperamental defects combined with subnormal intelligence corresponding to mental ages of 10 to 12.

Dr. Norwood East classified 283 convicted defectives according to their grade as follows—idiots 0, imbeciles 33, feeble-minded 244, and moral defectives 6. That idiots, who usually are so feeble physically that they have to be nursed in bed or chairs should present no problem to the criminologist is not surprising. The number of imbeciles that appear in the courts is small because an imbecile has not sufficient intelligence to plot any crime. When he does appear, it is usually on some such charge as that of indecent exposure; and his action is obviously not to be attributed to uncontrollable sexual impulse, but simply to the fact that he fails to appreciate the necessity of a social inhibition relating to such a natural function as micturition. Another typical instance

¹ Published by H.M. Stationery Office in 1929.

of criminal behaviour by an imbecile was that of taking his money-box out on the street on a day when there was a flag-day collection in the town. When the imbecile appears in court his appearance and behaviour immediately convince the magistrate that he is dealing with a person who is totally irresponsible, and usually the case presents no legal difficulty.

As we would naturally expect the large proportion of criminal defectives are of the feeble-minded grade. Many persons belonging to this category have a normal appearance, and it is only because some such feature as very slow response to questions or the foolish manner in which they have committed the crime that the magistrate requests they should be medically examined. The feeble-minded are generally charged with crimes that we associate with impulsive behaviour and social inefficiency—theft, sex offence and vagrancy, whereas charges of violence and house-breaking are less frequent. Rarely is a feeble-minded person charged with embezzlement, for the obvious reason that it is a crime that demands intelligence.

Of the five definitions in the Mental Deficiency Acts, that of the “moral defective” is of greatest interest to the criminologist. There was much controversy when the Mental Deficiency Act of 1913 was being drafted about the advisability of including the category of “moral imbeciles”, and after the Act was passed, there was so much controversy that in the Mental Deficiency Act of 1927, the name was changed to “Moral Defective”, and the phrase referring to punishment having no deterrent effect was omitted. But the chief stumbling block remains, namely, the term “moral”. Those who approach the problem of mental deficiency from the scientific standpoint maintain that it is incongruous to presume that a failure to observe the moral standards of any community can be regarded as an inherent defect in the sense that idiocy, imbecility and feeble-mindedness are due to inherent lack of intelligence. Many psychologists favour Prof. Burt’s suggestion that persons whom it was intended to include in the category of “moral imbeciles or defectives” would more appropriately, and certainly with greater scientific precision, be called the “temperamentally defective”.

Figures already quoted show that only 6 of 283 convicted criminals—the very group in which we should expect to find this type of case—were classified as moral defectives. Since this figure is fairly representative, it is obvious that comparatively little use

has been made of this section of the Act. Experience has shown that the anti-social behaviour of defectives in the large majority of cases can be attributed to their inferior intellectual capacities, and that there is no need for any such recondite hypothesis as an innate defect of "moral sense" to explain their behaviour.

At the same time, every worker in this field realises that there is a type of defective criminal such as that envisaged by the persons who framed the definitions of the "moral imbecile" or "moral defective"; but fortunately, there are not many of this type. Text-books on mental deficiency contain details of the case history of such defectives. In rare instances the intellectual ability of the individual is normal or even super-normal; he or she, however, has shown from an early age marked vicious and criminal propensities even when the family and social environment has been most conducive to normal behaviour. Some of these cases subsequently become insane, and so their behaviour in youth was probably due to a psychotic condition in its earlier stages. But there are others who develop no psychotic signs, and it is for this small group some category such as the "temperamentally defective" is necessary. The defect in these cases is fundamentally one of emotional instability or imbalance; but much further research and systematic observation of this small group of criminal defectives is required, so that we may have a clearer understanding of the real nature of their defect.

Having outlined the standards and criteria accepted in this country for the certification of individuals as mentally defective, we return to the query concerning the disparity between the estimates made by the expert witnesses to the Royal Commission of 1904, and the actual number of criminal defectives dealt with since the Mental Deficiency Acts became law. In view of the strong national sentiment concerning the freedom of the individual in this country, possibly the medical expert has erred on the side of being over-cautious in formulating his standards. A comparison with the standards adopted in America and in many European countries suggests that there is some truth in this contention. Many scientific studies on mental deficiency in America have included large numbers of individuals with a mental age as high as 12 in the category of "moron". Similarly in Germany the majority of persons with a mental age of 12 and under have been regarded as "oligophrenics". But one thing is certain, no judge,

magistrate or jury would countenance such standards being applied in this country. As regards mental endowments the gradation from the normal to the abnormal is continuous, and where the cleavage is to be made is likely to remain a matter of dispute for many years to come. When such drastic action as limiting the freedom of the individual may result from the certification of an individual as a mental defective, it is well that the expert should, without compromising his scientific integrity, bear in mind the attitude of the general public. Many who deal with such chronic social problems as recidivism, slumdom and pauperism believe that the medical experts in this country have deferred too much to public opinion in adopting such conservative standards of mental deficiency as those outlined above.

Whilst it must be admitted that up to the present the proportion of criminals dealt with under the Mental Deficiency Acts has been considerably below what the report of the Royal Commission had led us to expect, the proportion is larger than the figure of .42 per cent. based upon Dr. Norwood East's data. Doubtless a considerable number, but what this number is it is impossible to estimate even approximately, of the mentally defective persons in the Certified Institutions of this country were potential criminals, and had they been left in the general community would, sooner or later, have appeared in the courts. Dr. Penrose collected statistics relating to a number of civilised nations which indicate the proportion of the population segregated in mental institutions and the proportion of the population in prison in each country. These statistics show that there is an inverse relation between these two proportions; countries in which the incidence of the mental institution population is relatively high have a low incidence of prison population and vice versa.

Doctors and psychologists, who have had opportunities of examining large numbers of criminals and young delinquents, have collected many data which suggest that in the future the mental expert will make a more substantial contribution than he has made up to the present to criminology. This will come when his technique for examining the emotional aspects of human behaviour has been improved. At present in making a diagnosis of mental defect the intellectual aspect of behaviour predominates; and this is natural because it is possible to make fairly accurate measurement of an individual's intelligence and of his special intellectual capacities. But in dealing with the emotional or tem-

peramental aspect of behaviour, we have to rely on qualitative criteria which cannot be standardised.

Many researches carried out in various countries have substantiated, especially with regard to recidivists, Goring's main dictum that "defective intelligence is one of the primal sources of crime". In the case of the majority of recidivists, however, the defect is not sufficient in degree to enable the medical expert to state that they are feeble-minded. There is also a consensus of opinion that these recidivists are emotionally unstable or abnormal, but not to such a degree that they can be said to be mentally defective on this score alone. This hybrid defect of intelligence and temperament explains adequately the anti-social behaviour of large numbers of recidivists. In the administration of justice we are primarily concerned with the criminal as an individual and not with theoretical standards of intelligence or criteria of temperament. If the behaviour of the criminal can be shown to be due to the fact that he has not the mental endowments to behave as a normal person should in the circumstances, then it is only right and reasonable that he should be dealt with accordingly. Whether some modification of the Mental Deficiency Acts should be made to enable such recidivists to be brought within their scope or whether a new Act should be passed that would enable them to be dealt with together with other types of socially inefficient persons who are a burden on the community is a matter of secondary importance. What does matter is that it should be clearly recognised that their criminal behaviour is due first and foremost to the individual's mental handicaps. Short periods of incarceration in prison alternated with periods in the general community in which he cannot hold his own, is expensive to the State and unprofitable to the criminal. Until a more scientific and humane method of treating this type of criminal is adopted we shall not deal satisfactorily with the hard core of crime, namely, recidivism.

The defective criminal presents some unique problems of a legal nature upon which the medical expert is often expected to give an opinion. For instance, when the defective comes into court, the magistrate often seeks the opinion of the doctor whether the prisoner is fit to plead. Apparently there is no general ruling on this point, and each case is dealt with upon its own merits. If an imbecile appears in court usually his appearance and demeanour are sufficient proof to the magistrate that he is unfit to plead, and the same applies to some of the more retarded feeble-

mined persons. If fitness to plead implies that the accused is capable of understanding the difference between a plea of guilty, and one of not guilty, of instructing counsel, of challenging a juror, of examining witnesses, and of understanding and following intelligently the evidence and proceedings in court, then probably, all mentally defective persons with the exception of the few high grade feeble-minded and some moral defectives are unfit to plead.

Criminal responsibility presents a thorny and difficult subject. Fortunately, for the medical witness, he is not expected to give an opinion as to whether the accused is responsible for his behaviour; this is a matter for the jury to decide upon the evidence placed before them. The function of the doctor is to examine the patient's mental condition and to state the facts, especially those bearing upon the criteria specified in the MacNaghten rules, namely, whether the accused at the time he committed the act was labouring under such a defect of reason, from suffering from disease of the mind as not to know the nature and quality of the act he was doing, or, if he did know it, that he did not know he was doing what was wrong.

The task of the doctor in ascertaining these facts is relatively simple in the main. The condition of the person who is being examined, if he be mentally defective, is much the same as it was when he committed the act. This is not the case always when dealing with insane persons; the mental condition may be very different at the time the doctor examines the patient from what it was when the act was committed. Usually, in the case of defective criminals the facts can be presented simply and clearly. From the medical and scientific standpoint, the mentally defective adult is simply a person of adult age with a mind of a child; and it is possible to give a fairly accurate estimate of a child's age. This simplification of the issue should render the task of the jury relatively easy; in actual practice, however, the opposite appears to be the effect produced. Possibly this arises from the deep-rooted distrust of the expert witness; the jury may think that when his evidence is most intelligible to the lay mind it is likely to be least reliable.

Criminal responsibility in the case of a moral defective is a highly contentious subject. Many of his acts are impulsive and even obsessional, but have not the amnesic feature of post-epileptic furor. Until medical psychologists have been able to clarify the scientific conception of moral defect, they cannot be expected to make any distinctive contribution in such cases on the subject of responsibility.

Sections 8 and 9 of the Mental Deficiency Act of 1913 give the procedure for dealing with criminal defectives. If any person has been found guilty of a criminal offence punishable with penal servitude or imprisonment, and the Court is satisfied on medical evidence that he is a defective, the Court may postpone passing sentence, and may make an Order sending the defective to a certified institution or placing him under guardianship, or as an alternative, the Court may direct that the responsible Local Authority should present a petition to a judicial authority to issue an Order. A defective detained in prison can be transferred to a Certified Institution, or placed under guardianship by an Order of the Home Secretary (Section 9). Defectives with criminal, violent or dangerous propensities are usually sent to State Institutions which are maintained and managed by the central authority—the Board of Control.

Both the criminologist and the social worker who have a sound knowledge of mental defectives will agree that the problem of the criminal defective is far from being solved satisfactorily. It is a hopeful sign, however, to see more co-operation between lawyers and doctors in this field. It is well to recognise that the legal and medical professions approach the problem of crime from different standpoints. The lawyer's chief concern is the welfare of the community, whereas the doctor is primarily concerned with the individual. The *law* is at the focus when the lawyer considers the case, and the *criminal* when the doctor considers it. The synthesis and harmonising of these two standpoints appear to constitute one of the chief problems for criminology at present.

V

PSYCHOPATHIC CONSTITUTION AND CRIMINAL BEHAVIOUR

By PROF. D. K. HENDERSON

THE place in civilised society of the person suffering from a psychopathic disposition or constitution has never been clearly defined, and yet there is no more urgent legal and medico-social problem. Unfortunately neither our legal nor medical systems have become so enlightened as to suggest any adequate course of action. The lawyer and the doctor have worked too independently and have never learned or seen the advisability of pooling their experience. Their training of course has been vastly different. A good deal of the doctor's work consists in the interpretation of what is subjective, whereas the lawyer deals essentially with the objective, with those things which can be demonstrated, with facts as facts, with certainties, with conditions where there is little or no chance of error. The doctor thinks in terms of the individual, the lawyer is concerned with the offence; the doctor thinks of what measures can be adopted to benefit his patient; the lawyer of how he can protect society; the doctor requires to consider the force of emotional or instinctive forces which may not be fully conscious, the lawyer sees matters from the stand-point of reason and free-will and of conduct determined and controlled at the level of consciousness. Yet the more experience I gain in medico-legal work the more certain I become that further progress will only result from our combined efforts. Our aims are not opposed. We are more or less equally concerned with promoting the recovery or reformation of the individual as well as with the preservation of society in its highest efficiency. There is much evidence to show that the retributive attitude of an eye for an eye, and a tooth for a tooth is passing away, and many of those who administer the law are no longer satisfied by passing arbitrary sentences, but are deeply conscious of the humanitarian and medical aspects of re-formative work. It has been proved before, and it will be proved again, that such things as order, justice, happiness, efficiency, cannot be adequately obtained or maintained by the power of fear as a means of deterrence, and an excellent statement by Sir John

MacDonell illustrates the point: "Fear brings back the primitive conception of the functions of courts; not necessarily, or indeed often, personal fear, but fear of changes; fear on the part of the upholders of the old order; fear of the discoveries of new truths; fear of emerging into the full light. Where such fear is justice cannot be; a court becomes an instrument of power; judges are soldiers putting down rebellion; a so-called trial is a punitive expedition or a ceremonial execution—its victim a Bruno, a Galileo, or a Dreyfus."

Superficially it might be thought that the terms Psychopathic Constitution and Criminal Behaviour were more or less synonymous, and that no useful purpose would be served in considering them apart. While the inter-relationship is very close, yet there are points of differentiation which require much more elucidation. There has been a tendency to apply the term Psychopathic Constitution in a general way, almost indiscriminately to every form of nervous or mental disturbance accompanying criminal behaviour, and even to disordered conduct of every kind. It is true, of course, that every one who exhibits criminal conduct shows certain traits in his make-up or nature which differentiates him from his more socially-minded and better adapted neighbour, traits which point to some more primitive or regressive streak in his nature which he has never been able to master or control so as to fit him successfully into the social milieu. The mere presence of such traits does not, however, connote, necessarily the presence of a psychopathic constitution, but only draws attention to instinctive forces which may be liberated in a variety of ways by numerous causes, *e.g.* by organic disorders of the brain of a diffuse or focal nature, by biochemical and metabolic changes, by the cathartic crisis described by Wertham, or by the more incalculable forces of heredity and environment. While, therefore, we can say that every criminal may show certain psychopathic traits, yet everyone who is psychopathic need not be a criminal; his psychopathy may be something by itself, or may merge into psychosis or neurosis. The presence of the psychopathic constitution should only be advanced as a mitigating circumstance in assessing criminal conduct where it has attained a degree of specificity which cannot very well be questioned. It cannot be too strongly stressed that, medically, it is not our desire to exculpate everyone who is guilty of criminal conduct by advancing hypotheses which have not been proved; in fact, numerous cases are on record where,

medically, we should be in favour of much more prolonged care and detention than is, at present, sanctioned by our laws.

For many years the law has recognised that the person of unsound mind, or anyone suffering from a defect of reason amounting to idiocy or imbecility, is not susceptible to the same criteria as those applied to the sane, and special provision is made whereby they can be cared for in a considerate manner. But gradually it is being more fully recognised that there is another group of cases which are neither insane, nor defective, but who require special consideration. Lord Alness referred to this group in his summing up in the case of *Rex v Savage*: "Formerly there were only two classes of prisoner, those who were completely responsible, and those who were completely irresponsible. Our law has now come to recognise in *murder cases* (italics are mine) a third class, those who, while they do not merit the description of being insane, are nevertheless in such a condition as to reduce the quality of their act from murder to culpable homicide . . . there must be weakness or aberration of mind; there must be some form of unsoundness; there must be a state of mind bordering on, though not amounting to, insanity; there must be a mind so affected that responsibility is diminished from full responsibility to partial responsibility, the prisoner in question must only be partially responsible for his action."

The above opinion has appeared to some to open the door very wide, so wide in fact that it is becoming a rarity to have a successful issue to a capital charge, but yet there is much to be said for it. It seems to me to be particularly applicable and serviceable in the case of psychopaths accused on a capital charge. It has not as yet been accepted by the English courts. Why, however, should the application of the above dictum be reserved for murder cases only? Surely it might be very well extended to all other forms of criminal conduct. For instance, in cases of serious assault, and in sexual offences there are often very excellent reasons why the full weight of the law should not be exercised, and where the position could be more adequately met by other than penal treatment. In order to make the position quite clear let me say once more that the psychopathic person is not, necessarily, a criminal; he is not of unsound mind in terms of certifiability for admission to a mental hospital; he is not mentally defective in terms of intelligence; and yet in certain instances he may show approximations to one or all of the above categories. So long ago as 1835 Dr. J. C. Prichard,

a Bristol physician, gave a clinical description of this group. Prichard did not use the term psychopathic—that was left to Koch at a much later date (1888)—but under the title of *moral insanity* and *moral imbecility* he pointed out that people might be affected in their feelings and affections even although the intellect and understanding remained unimpaired. He said: “There is likewise a form of mental derangement in which the intellectual functions appear to have sustained little or no injury, while the disorder is manifested, principally or alone, in the state of the feelings, temper or habits. In cases of this nature the moral and active principles of the mind are strongly perverted or depraved; the power of self-government is lost or greatly impaired, and the individual is found incapable, not of talking or reasoning upon any subject proposed to him, but of conducting himself with decency and propriety in the business of life.” The above description implies, although Prichard does not say so, that the disordered conduct described is governed by the unconscious or instinctive forces of the individual, and thus is differentiated in many cases, from the premeditated conduct of the criminal. If it were not so I could appreciate clearly how the lawyer might maintain that every criminal who was of sound mind and fit to plead to the charge against him corresponded exactly to Prichard’s description. The point of differentiation is that Prichard postulates “a form of mental derangement”, something which is uncontrollable, which indicates a diseased mind, and, therefore, is not subject to reason and free-will. Such a person has as little power, spontaneously, to control his conduct as the paranoiac to banish his delusional beliefs. The patient cannot understand his own conduct. He often describes it as something quite contrary to his ordinary nature, but it occurs so frequently, and is so inexplicable, and obsesses and dominates his mind and conduct so much that he comes to accept it fatalistically, and to adopt a defeatist attitude. The unintelligent layman has little or no patience with such individuals; he thinks of them in terms of original sin, advocates harsh measures, and believes that they are the product of too lenient and indulgent parents. He fails to appreciate that such problems may crop up in any family, the members of which have all been treated in exactly the same way, and that severe punishment has no deterrent effect, but merely aggravates the spirit of rebellion and antagonism which has already been revealed. On the other hand, those of us who are practicing psychiatrists appreciate the fre-

quency of such cases, and know the anxiety parents experience lest their children should commit serious offences and thus injure themselves and produce undesirable publicity. The fact that such cases are referred long before any public or anti-social offence has been committed is perhaps the best index of their specificity. Psychopathy, therefore, is not simply a trumped up defence in response to a criminal charge, but has been present in the individual's constitution long beforehand. Furthermore, such cases occur in every rank of society, and the conduct exhibited is often at total variance with the circumstances of the person's life; that again is one of the ways in which such disorders of conduct differ from those of the criminal. Irrespective of the cause, or even in the absence of any ostensible cause, we know that those who constitute the psychopathic group are people who from an early age have shown conduct disorders, often of an outrageous nature, accompanied by emotional instability, which has proved a constant perplexity to all who have strained to help them. The psychopath fails to adapt to reality, he cannot accept life as it is, he leads an independent, individualistic type of existence impervious to his duty or regard in relation to his relatives and friends; he suffers from an insanity of altruistic feeling. He is governed entirely by the pleasure principle; he fails to grow up; he seldom benefits by experience. "The judicial, deciding, selecting processes described as intelligence and the energising, emotivating, driving forces called character" do not seem to be capable of being brought into play.

In my book, entitled *Psychopathic States*, a rough division was made of the varying types in terms of (1) the predominantly aggressive, (2) the predominantly passive or inadequate, (3) the predominantly creative. I have shown how the above groups are bound together by the underlying constitutional traits, but in this presentation it is the two former groups only which require consideration.

SUICIDE

Suicide is perhaps the best and truest example of the specificity of the psychopathic state. In suicide the aggressive impulse is directed against the individual himself in an attempt to expiate his own difficulties or guilt feelings, or as a gesture of revenge. Suicide is the expression of the individual's inability to adapt to the conditions of life, his precipitate and tragic retreat from reality in the vain endeavour to find that Nirvana which his individualis-

tic soul has longed for. Formerly this act was regarded as a heinous crime meriting the most condign punishment, but now everyone regards the suicide as a sick person, whose situation calls for sympathy and understanding, and it is seldom indeed that the law is invoked to punish the suicide even although the appropriate penalty is still laid down in the statute books. The threat to commit suicide and the attempt to effect it has always, quite naturally, been identified with states of depression, but it is something much more than that, it has a far wider significance. Suicide may often be the quick, abrupt response of the ill-balanced, emotionally unstable, disillusioned individual, who comes to realise that he cannot have things all his own way, and who is unwilling to adapt himself to others. It is a gesture in response to frustration, and a more or less unconscious attempt to square his account with the World. In other words, the potential suicide never learns to accept the good with the bad, he seeks the lime-light even in this distorted way, and is essentially the exhibitionist who has never learned from experience to control that more emotional, instinctive side of his nature, the harnessing of which leads to socially acceptable conduct. That is how his psychopathic state shows itself. If the above statement can be accepted then it is not too much to ask that the same understanding, charitable attitude should be applied to the psychopath who is aggressive to others, or who may show other anomalies of conduct, as is applied to the psychopath who murders himself. The object is different but the underlying principle remains the same. Suicide and murder are similar twins. Popular opinion has always held the view that the psychiatrist is a soft-hearted sentimentalist who believes that everyone is "not quite all there", and that he is willing to support the most specious excuses in the face of the most dastardly crimes. That opinion is far from the truth. The psychiatrist is no more anxious to live in a disturbed, disorderly world than his neighbour is, and in many cases (as will be instanced later) he would take a much sterner line than the law sanctions. There is no fear that the diagnosis of psychopathic constitution will be overdone, and in any case, those who are so diagnosed require an amount of care, treatment and supervision which, as yet, has never been provided for them.

MURDER

Out of a series of forty-nine cases of murder in which I have examined the accused on account of his mental state, in four instances only have I been able to make a diagnosis of Psychopathic Constitution. In contrast, twenty-one were of sound mind, nineteen were insane, and five were mentally defective. Of the above mentioned four cases the victims were a brother, a paramour, and two young women whom the accused in each instance had met for the first time during the evening they were murdered.

In each of the above cases the history, throughout their lives, showed that they had been difficult, unruly people, who had been subject to outbursts of temper during which their conduct became ungovernable. One in his school-days had made a dangerous assault on his school-master, two had attempted suicide, another had seriously assaulted his sister, and all had had previous police convictions. One had on separate occasions been certified as a moral defective and later as a person of unsound mind. At their trials two were sentenced to be detained during H.M. Pleasure, one to fifteen years penal servitude, and the other to penal servitude for life. Their lives had been strikingly similar as all of them were egocentric, individualistic types who had never shown any consideration for others, and had always regarded themselves as a law to themselves. In the face of their crimes and their sentence they exhibited a callous indifference. It is satisfactory to note that while the law took a serious view of their misdemeanours, yet it recognised the twisted nature of their personalities, and made due allowance, therefore, by not exacting the full penalty. The fact that two were sentenced to H.M. Pleasure merely meant that the sentence became an indeterminate one, and it is just in such cases that an indeterminate sentence is fully justifiable. Such persons are far more dangerous than any other, far more so than the sane criminal, or the insane criminal who recovers, because they are much more incalculable. If, according to the dictum of Lord Alness, they may be considered only partially responsible they should not be treated with less stringency, as regards supervision and discharge, but with more.

Those charged with dangerous assaults belong to the same class as murderers, and it is more by the Grace of God and their own good fortune that they are not arraigned on a capital charge.

Their record too, shows a history of continuous anti-social conduct which has been in evidence since adolescence. Out of a group of twenty-seven such cases seven were regarded as psychopathic. The callousness, stupidity and thoughtlessness of the crimes committed was their outstanding feature. For instance, a youth, eighteen years old, stole a motor car and when two constables jumped on the running board in an attempt to arrest him, he drove the car in such a reckless manner as to endanger their lives; one was so seriously injured that it was believed he would never fully recover. In tendering a plea of not guilty the defence intimated a plea that "at the time libelled the accused was affected by mental and emotional instability or abnormality". Throughout his life he had proved a most difficult youth. An only child, he had been brought up indulgently, and exhibited an ungovernable temper, explosive in quality and reminding one of the furor of the epileptic. He lived in a world of make-believe and arrogated a position he had never held. During examination following his arrest he maintained a self-satisfied attitude, and yet had a complete understanding of his position and of the charge against him (attempted murder). The plea of the defence really amounted to one of Partial Responsibility, but the Advocate-Depute pointed out that such a plea, as defined by Lord Alness, was only applicable in murder cases to effect a reduction of the charge from one of murder to culpable homicide. Curiously enough, in this case, Lord Alness was the presiding judge, and his summing up described the case as "one of the most extraordinary" in all his experience. He stated that, if the defence prevailed, a man who was claimed to be irresponsible for his actions and who might again become so, went out to the world a potential peril to himself and others. The prisoner was found guilty but sentence was restricted to one year's imprisonment. The summing up was clear, the issues were made plain, but a sentence of one year's imprisonment can only be regarded as an anti-climax. If the purpose of the sentence is to effect a moral readjustment of the individual, especially of a youth with such a previous record, then it becomes impossible to lay down a time limit. The discharge of such a youth should be dependent on the presence of a sense of social responsibility irrespective of how long that may take.

A number of the other cases were a great deal more complicated, but they need not be discussed in any great detail. For instance, one man had on different occasions been charged with

such offences as (1) theft and housebreaking, (2) lewd and libidinous practices, (3) rape and attempted murder, (4) serious assault. For certain offences he was given a prison sentence; on two occasions he had been certified as insane (episodes of impulsiveness with transitory hallucinations). Certain psychiatrists who had examined him believed he was malingering. The truth of the matter was that intellectually he was well endowed, but throughout his life his conduct had been turbulent and uncontrolled.

A somewhat similar record was presented by a man, twenty-three years old, whose conduct disorder first manifested itself when he was eight years old. At that time he was considered to be uneducable, but soon it was found that he was very intelligent and was sent first to an Industrial School, and later to Borstal. Following his discharge, he received repeated prison sentences, all of which proved entirely ineffective. My examination showed him to be a clever man, a glib talker with no features pointing to neurosis or psychosis, but who seemed quite inaccessible and incorrigible.

Another, a youth, seventeen years old, almost killed and certainly permanently disabled his employer's son by striking him on the head with an axe. This lad had been educated at an Approved School, and later was discharged from the Army as he had not proved amenable to discipline.

Such examples indicate at once the dangerousness of this type of case. They seem to be entirely lacking in forethought and judgment, they reck nothing of the consequences of their stupid acts, and they act in a manner which is inexplicable to themselves and without motive. They fit into Macaulay's description of George Fox: "His intellect was in that most unfortunate of all states—too disordered for liberty and not sufficiently disordered for Bedlam."

SEXUAL OFFENCES

The majority, in my experience, have been homosexuals, but in addition I have had the opportunity to examine the mental state of many others charged with rape, indecent assault, interference with young girls, bestiality and exhibitionism. After some particularly flagrant case which has attained publicity there may be a great stirring up of popular opinion with the expression of totally divergent views. On the one hand, an irate judge will utter the

most terrifying diatribes stating that all such offences must be stamped out, that they are due to negligent parents, that it has been a question of sparing the rod and spoiling the child, and that severe corporal punishment and penal servitude will knock it out of them.

On the other hand, there is a large body of opinion which takes an equally extreme view, and believes that all such cases should be examined and treated by the psychiatrist. At one time I was strongly in favour of that course, regarded the problem of the sexual offender as a purely medical question, and was critical of any other attitude. My experience has, however, rather altered my opinion. It is only in a comparatively small number of cases that the sexual offence can be linked up with the presence of mental illness or disease; in the vast majority of cases the individual in his conversation, reasoning and judgment is just as sane a man as his next-door neighbour. It is his sexual conduct only which is disordered, and it is not easy to decide how much the impulse to behave in this anti-social manner is governed by forces which are instinctive or by those which can and should be controlled. Some of those involved are anxious to receive help so as to develop to a more mature level, but the others are content to be as they are, and indeed derive a good deal of gratification from being different from their neighbours. The subtleties of the condition are well expressed by Proust in *Cities of the Plain*. "With what you call 'young gentleman', for instance, I feel no desire actually to love them, but I am never satisfied until I have touched them, I don't mean physically, but touched a responsive chord." Taken in such a sense homosexuality, latent or manifest, pervades society, and is so much a part of everyday life that it is impossible so to speak to stamp it out. For one reason or another, as a result of heredity, of glandular dysfunction, of environmental circumstances, there are almost bound to be a certain number of persons who fail to reach sexual maturity (hetero-sexuality), and who remain at a narcissistic or homosexual stage. We should not condemn them; we have no right to do so, they are as much the victims of their constitutions as we are of ours, and we can only step in when their conduct becomes subversive of society, or when they request help so as to enable them to reach a more mature level. Because of this anomaly only in their sexual development we are not entitled to describe them as psychopaths; in all other respects they may be perfectly decent, law-abiding citizens. It is only when their sexual abnor-

malities are complicated by the other features which have been described that we are entitled to call them psychopathic.

In most instances the offence had been constantly repeated; usually it had been present for years before it had been found out. The idea that such offences are peculiarly prone in elderly men with a prostatic enlargement is largely a myth. The ages of those involved varied from early manhood to advanced years—but those who were elderly had usually been indulging themselves for years and had never been found out. Very few expressed much regret, some merely accepted their position in a complacent manner, others rather gloried in it. The persistence and repetitive nature of this type of offence is well-shown by the following summary which is not unusual.

(1)	26. 2.16	Indecent Conduct	10 or 5 days.
(2)	15. 4.19	„ „	30 days.
(3)	12. 2.20	„ „	60 days.
(4)	10. 6.20	„ „	60 days.
(5)	23. 2.23	„ „	60 days.
(6)	29. 8.24	„ „	60 days.
(7)	13. 5.25	„ „	60 days H.L.
(8)	9.12.25	„ „	30 days.
(9)	8.10.26	„ „	8 months.
(10)	28. 9.31	„ „	12 months.
(11)	3. 1.36	„ „	18 months.
(12)	10. 9.40	„ „	18 months.

In such a case any reasonable person might think that the offender was of unsound mind, but yet I was unable to find any grounds on which to certify him as suitable for mental hospital treatment. The futility of the short-term sentence is obvious. Considering the matter in its entirety we are forced to admit that while sexual offences are perhaps more what may be described as medico-social problems than anything else, yet we have so far not discovered any adequate way of dealing with them. They involve people who cannot rightly be considered either criminal on the one hand, or mentally ill on the other. They are not, I believe, fully or adequately responsible in that they are controlled and dominated by forces which they cannot understand, and yet it would be most unfair, and, in fact, impossible, to certify them as of unsound mind, and confine them for treatment in a mental hospital. They require some other more specialised provision. They approach nearer the psychopathic group than any other.

PREDOMINANTLY PASSIVE OR INADEQUATE

The numbers which constitute this group are very numerous, and their disorder of conduct is either in the direction of lying, thieving, fraud, truancy, etc., or else the bias may be towards states of emotional instability with cycloid or schizoid features. They are people with glib tongues, confiding manners, superficially attractive personalities, who may make an excellent impression—until they are found out. They may be responsible for extraordinary situations. For instance, a young woman of good looks, and engaging manners, made the acquaintance of a young widower who thought she would prove the ideal wife, and an excellent mother for his young child. It should be noted that the widower was a man of standing who had reached a position of considerably responsibility, and was regarded by his relatives and friends as endowed with more than the average amount of common sense. He became infatuated, and during the engagement, and for a few days after the marriage had been solemnised lived in a state of bliss. She had represented herself as the daughter of a wealthy South American merchant, dressed extravagantly, told the most colourful stories of her life abroad, and of how she had antagonised her father by refusing to marry the man he had suggested for her. Previous to the marriage she purchased a most expensive trousseau; the account for which her fiance endorsed as her usual monthly allowance had not come forward. During the honeymoon it soon became apparent that she was not what she had represented herself to be. Her habits were unhygienic, her stories were found to be falsehoods, and finally she admitted that she had acted a lie. Her parents were of humble origin, she had never lived abroad, she had always lived by her wits, passing from one adventure to another, and for a time she had been a patient in a hospital for nervous patients. On the return from their honeymoon her husband made provision for her and then left her. Shortly afterwards she committed adultery, and he obtained a divorce.

I have records of two other cases of essentially the same type as the above where marriage was effected as a result of false pretences.

A case of a different type was that of a young man, twenty-two years old, who was arrested for masquerading as a surgeon in the

Royal Navy. He was the wealthy son of wealthy parents who had been given the advantage of all that money and education could do. No obstacles had ever been put in his path. He entered a famous medical school, during a period of five years his parents received glowing accounts of his progress; he described distinctions which he had gained, and eventually stated that he had graduated as the most distinguished student of his year. Following his arrest it was discovered that his stories were a tissue of lies. Actually, he had entered a medical school and had gained a smattering of medical knowledge, but there the matter ended. He had passed no examinations, he had gained no distinctions, he had not graduated. He was a charming, good-looking young man who characterised his conduct as "sheer madness". He could not understand how he had come to live in such a world of make-believe. All who had associated with him had considered his intellect and general knowledge as well above the average. He was not prosecuted; the case was referred for medical care and treatment.

The newspapers are filled with reports of similar cases, people who tell tall stories, pose as men of means, run up debts, obtain money by false pretences. One young man described himself as suffering from an inflated ego and as living in a world of dreams; he believed that treatment in a mental hospital would be a blow to his prestige. Another represented himself as the son of a distinguished surgeon, wrote letters of introduction and recommendation purporting to be from his father, and eventually found himself in the hands of the police for obtaining possession of motor cars for which he could not pay.

Almost without exceptions the life history of such persons shows that since early childhood they have been entirely unreliable. They have changed from one job to another, they have shown no persistence of effort except in their attempts to out-wit the police, their parents, or their employers, and they have never profited by experience.

Another group of cases which has always proved a puzzle are the shop-lifters, women usually, who frequently repeat the same offence, and obtain very little material satisfaction for their efforts. The articles stolen are often quite worthless compared with the social position of the women who steal them, and yet they must represent some symbolic value. My personal experience of such cases has not been extensive, but I have always been at a loss to

understand them. For instance, a woman, forty-five years old, had had two previous convictions for similar offences for which, on each occasion, she had been fined. On the occasion on which I examined her her offences had been spread over a period of many months during which she had stolen stockings, vests, knickers, gloves, toilet sets, and so on, from a variety of shops. All the articles stolen were subsequently found in her own house. She had no use for any of the things as she had always plenty of everything, and was in comfortable circumstances. There were no significant features in her medical history. She was unable to explain her conduct, she described it as strange and absurd, and yet at the various times on which she had stolen the articles she had known clearly what she was doing.

A second case was that of a respectable married woman, forty-seven years old, who stole a dress. At the time of her arrest, when she was leaving the shop, she was found to have over £10 in her possession. The above act was in striking contrast to the record of her former life and was entirely foreign to her ordinary personality. Yet, again, she had a clear enough appreciation of this strange, foolish act. I was unable to demonstrate any psychotic features, and merely emphasised the menopausal period even although I did not consider it had had any material bearing.

These cases can be taken as a sample of others of a similar type. Surely it is not enough to be satisfied merely with saying that the person is sane or insane. The conduct exhibited by these women was strange, erratic, unaccountable, something which must have been determined by the deeper unconscious or instinctive forces of their natures. It may be that it is not completely satisfactory to designate them as psychopathic states—but that diagnosis is nearer than others. Their actions are closely akin to those of the child who snatches whatever attracts him and maintains that it belongs to him. In my experience the relationship of such states to sexual abnormalities or disorders has not been conspicuous.

GENERAL SUMMARY

What is the answer to the problem which has been presented? I have no panacea, no cut and dried plan which can, at once, be put into operation, and yet it should be possible to evolve some method, medical and legal, whereby greater help can be provided at a time when it is likely to be most successful. It is obvious that

the situation which has been outlined is extremely complicated, but the fact that we have gone some way to delimit the group should be of some assistance in its elucidation. It is, at any rate, clear that we can no longer be content with a simple division into the sane and the insane, and that special provision, medical and legal, requires to be made for some, at least, of the types which have been described. The complexity of the group is more apparent than real. The multiplicity of forms or symptoms simply depend on individual idiosyncrasies or tendencies, for underlying them we have personalities which correspond, more or less, to a uniform type. What the cause is we don't know. Such cases may crop out at any time in apparently healthy families, who live under the most favourable environmental conditions. But just as people differ in their physical and intellectual attributes, so, too, we have people who differ in their social or moral qualities, and never conform to the same standard of life as their neighbours. They are solitary, friendless, individualistic, and take infinitely longer to mature, emotionally and socially, than their brothers or sisters. It seems only fair, therefore, that in our efforts to deal with them we should refrain from applying the same standards as in the cases of those who act with premeditation and malice aforethought. We are dealing more with dangerous children than with criminal adults!

In a general way it may be suggested that all cases exhibiting strange, motiveless, stupid conduct, where no special purpose is served or accomplished, should be investigated with the greatest care, and should be referred to the psychiatrist for an expert evaluation. In many cases this could be done long before there was a possibility of court proceedings being instituted. But even if the case was one for trial, then it is suggested that the courts of our large cities might employ a court psychiatrist as as to assist the judge in understanding all the circumstances, and thus be a help in deciding the appropriate punishment or treatment. No one wishes to see the development of more specialised types of institution than are already in existence, but those we have should be developed and extended. For instance, Approved Schools and Borstals have proved their value, the results attained are excellent but, I believe, they could be improved upon. They are especially applicable for the treatment of psychopathic persons. The difficulty, however, exists that the above establishments are too restricted by statute, both in relation to the age of those entering

them, and the duration of time they require to remain there. More elastic arrangements are required. It should not be necessary for a child to wait until he is fourteen years old before he can be admitted to an Approved School provided that it is clear that that is the proper treatment for him. Many children from eight years onwards are already proving a thorn in the flesh of their parents, and would do eminently well under the Approved School system. Really difficult cases would thus have the chance of a much longer time in which to effect a readjustment. The age governing Borstal treatment varies between sixteen to twenty-one years and this, also, I would like to see extended. Furthermore the duration of treatment under Borstal conditions is restricted to three years. That, in some instances, is not nearly long enough. It is impossible to lay down a time limit during which readjustment to social life can be effected. Some people take much longer than others, and I feel that it would be much better for the individual, and much safer for society, if we ceased being prophets, and were content to deal with facts as facts no matter how long it might take to find an adequate solution. For that reason I favour the introduction of an indeterminate sentence the question of discharge to be dependent on a sense of social responsibility. Under such a system many could be discharged earlier than is at present the case, while others would be detained much longer. To assist in such a plan the appointment of a psychiatrist to Approved Schools and to Borstals might be seriously considered. The use of the probation system could be expanded to an enormous extent, and adequate after-care could be utilised in the case of those who are discharged. The employment of the above methods would result in a much closer approximation of the views of the doctor and the lawyer.

It has often been said, and it is quite true, that in the case of the psychopathic person punishment has no deterrent effect, and in fact makes the individual more resentful towards society than he ever was before. For that reason it seems essential that the first offence should be investigated in every detail and from every angle. That is the time when, with appropriate measures, the best results may be expected. Far too often valuable time is wasted, for often it is only after many offences have been committed that any suggestion is made that the offender's mind may be at fault.

There is also much to be said in favour of the suggestion that a trial might appropriately be divided into two parts: (1) the guilt-

finding phase, (2) the treatment phase. For the latter purpose it has been suggested that the judge might consult with those who have had practical experience of sociological, educational and psychological problems.

Apart from the above general considerations we have reason to hope that the work of the Institute for the Scientific Study of Delinquency will lead to the development of individual methods of treatment of remedial value.

The core of the situation lies, however, in preventive methods of an educational, sociological and medical nature which have been developed and utilised from earliest childhood. It is only then that we will produce that greater state of social solidarity which is so much desired.

VI

FUNCTIONAL NERVOUS DISORDERS AFTER INJURY

By DR. D. R. MACCALMAN

THE principle that a workman may be compensated for injury or illness arising from an accident sustained during employment is surely praiseworthy. The Workmen's Compensation Act therefore marked a great advance in social legislation and for almost forty years many have greatly benefited from its provisions. Since 1906, however, there have been vast changes in types and conditions of work: social conditions and standards of living have altered almost beyond recognition; and, most important of all, advances in medical knowledge regarding the nature of illness and its treatment have been so great that the Act no longer subserves the fundamental purpose for which it was laid down. The Act was, of course, amended some seventeen years ago, and more recently government Committees and a Royal Commission have examined and made recommendations upon various anomalies. The Workmen's Compensation Act is, nonetheless, regarded as one of the most difficult branches of the law, mainly because courts find it exceedingly hard to evaluate the too often conflicting medical evidence which is presented to them. This is especially true in cases where a psychopathological disorder seems to be associated with or caused by the injury. In such cases lawyers find medical witnesses even more uncertain, vague, and unwilling to make an unqualified statement than traditional reputation has led them to expect. They contradict each other in so bewildering a manner that laymen are apt to disregard their evidence and base their judgment on their own opinions. Now we should note that laymen themselves are inclined to have strong opinions where psychological problems are concerned. They pride themselves that their beliefs are based on that vaunted but deceptive quality "sound common sense", but unfortunately their opinions are, in reality, determined very often by prejudice, hear-say, superstition, folklore and all the mechanisms by which the unconscious mind hides its true wishes, purposes and motives from conscious thought. Thus, in many cases, it is left to chance as to whether

justice is done to the worker or the employer. Again, we must remember that in psychological cases, much more than in cases of physical injury or illness, we are not dealing so much with a medical problem as with the application of medicine to a social problem. Finally, we should note that greater advances have been made of recent years in psychopathology than in any other branch of medicine. Even to-day certain medical schools only are up to date in their teaching; and the vast majority of doctors in practice to-day have had no formal instruction at all in this subject which is of such supreme importance in all compensation cases.

It may be very true that much progress has been made, particularly during the last twenty years or so, towards an understanding of human behaviour, but even this sum total of psychological knowledge is meagre and tenuous. In this branch of medicine there can be no dogmatism or precision, and courts must not expect as exact information as they receive on purely surgical or medical questions. Nonetheless, a certain body of knowledge, which may be regarded as reliable, has been built up, which should be useful in the settlement of compensation cases. The purpose of this chapter is to indicate what is reliably known of human reactions, normal and pathological, to injury or threat of it. The question of treatment whether of the individual himself directly, by readjustment of his environment, or by changes in legislation, will also be discussed.

CAUSATION

That an individual can suffer bodily harm, in, for example, head injuries where the brain substance is obviously lacerated, which in turn can cause serious mental and physical disturbance is obvious, and has always been accepted by medical and lay persons alike. It was only in 1866, however, that Erichsen suggested that similarly grave results could occur in cases where there was no obvious and immediate signs of injury. Erichsen termed this condition "railway spine", and his theory was subjected to much ridicule and criticism. In 1870 Beard first drew a distinction between disorders of organic origin and functional disorders, to which latter he attached the term "neurasthenia". Oppenheim almost twenty years later first used the term "traumatic neuroses". Despite violent opposition, on the grounds that functional disorder was just another form of malingering, doctors and lawyers slowly

began to accept the theory that a sudden, devastating experience, whether accompanied by physical injury or not, could cause a neurotic disorder. Once "traumatic neurasthenia" was accepted as a clinical entity, however, it was difficult to get them to accept any modification of this view. Even to-day a large body of medical opinion accepts the view that a single experience, or "shock", is sufficient to produce, in practically any individual, a fully developed neurosis or even a psychosis. This view is not, however, the accepted teaching in modern psychiatry, for there is an overwhelming accumulation of evidence that impersonal environmental happenings, no matter how virulent and terrifying, do not produce any lasting psychopathological state. Rather it is held that sudden, violent environmental disruptions only act as the releasing factor of a neurosis which was latent, or more often unrecognised, until that moment. The true etiological factors are intrinsic emotional conflicts dating from early childhood, though they may only be brought to light by some dramatic experience. These views are almost universally accepted to-day, but they were hotly opposed by the medical profession when they were first formulated, early in this century, by Freud, Jung and others. Even in the Great War psychiatrists naïvely believed in "shell shock"—a nervous condition supposed to be caused by damage to brain tissue from the blast of a high explosive shell—and many ex-service men are still receiving pensions on these grounds, even though they may be, in reality, cases of mental deficiency, hysteria, anxiety neurosis, psychopathic personality and the like. The experience of the present war should rid the world of this view for ever, for not only service personnel but the civilian population have gone through incredibly violent bombardment with no appreciable rise in the incidence of neurosis. Further, it has been shown, for example by Sutherland (1941), that in 36 per cent. of soldiers who developed neurosis there was unmistakable evidence of pre-existing neurotic reaction, and that 80 per cent. of them had had nervous traits indicating emotional instability.

Theoretically there should be no need to emphasise that as Ramsay (1938) put it: "... in such cases the soil is ready for the seed; in other words, that some mental conflict or maladjustment to life was already present and that the injury acted as an exciting cause of the psychoneurotic symptoms which developed subsequently." A very comprehensive review of supporting evidence is given by Brend (1938 and 1941) who points out, however, that

the outmoded reverse view is still held by physicians and distinguished public personages. Thus we find Mr. Ernest Bevin, in 1938, upholding the view that modern conditions of work alone are responsible for much nervous disorder. Some of the leading medical text books still teach the sufficiency of adverse external influence by themselves to cause a neurosis. For example, we find in the thirteenth edition (1938) of Osler's *Principles and Practice of Medicine* a description of traumatic neurosis which is identical with that in the first edition published in 1892! As Brend (1939) comments, "The experience of nearly fifty years is unnoticed and throughout the section there is no suggestion that intrinsic, psychological factors could have played even a part in producing the disorders. . . . When such teaching appears in current text books it is not surprising that many practitioners are fully satisfied that quite trivial, environmental factors can produce a neurosis, a psychosis or even a "progressive paresis". No apology is therefore required for the emphasis which is placed here on this fundamentally erroneous conception which has been so often upheld in courts of law. One's faith in the aforementioned sound common sense is shaken when one sees how naïvely and how readily lawyers have accepted it as a truism, which, according to legal theory, requires no proof when given in evidence.

There is, on the other hand, ample evidence in support of the more modern view that a neurosis which follows an accident is produced not by the physical trauma itself but from the psychological concomitants of the injury. Brend (1941) advances three grounds in favour of the psychogenic theory (1) that there is no clinical difference between a "traumatic" neurosis and a neurosis resulting from other agencies.²⁵ (2) A traumatic neurosis is far more likely to be associated with slight injuries than with serious lesions. In this connection the writer has noted (1942) that in service orthopaedic cases "there seems to be a co-relation between the loudness of the complaint, the triviality of the foot deformity and the lowness of the mental age." (3) We do not expect to find neurotic disorders arising from illness or disease, nor do we hear of "post operative neurasthenia". Nor, as the writer has suggested (1938) do we meet with traumatic neuroses in those engaged in sport, except perhaps in professional footballers.

But how, it might be asked, does a neurosis arise after an accident if it is true that an injury *per se* cannot cause a mental disorder. This can best be illustrated by quoting an actual case.

A man, aged 30, employed in the building trade, was working on a scaffold when the chain broke and he fell thirty-five feet. There was hardly any loss of consciousness, but he was greatly distressed to find that he couldn't move his legs. He was removed to hospital, quickly recovered and was sent home in a few days. Soon afterwards he relapsed and was readmitted to hospital where he was kept in bed for a month. When he returned home, however, he still felt weak, giddy and had pain in his back.

I first saw him three months after his accident and found that he was in a state of acute anxiety. He was excited, restless, and trembling; his pupils were dilated, his skin alternatively flushed and pale. He complained of vertigo, backache, loss of feeling in the back of his head—"it is like a stone"—loss of sensation in the right hand and weakness on that side. When he had to go anywhere he had attacks of panic; for example, when he was given an appointment to see me at the hospital, he became so anxious that he had to spend a week in bed. He was convinced that there was something organically wrong with his head and spine.

The first clue to the origin of his trouble came when I asked him what he thought was wrong with his head. Looking at me with some surprise for questioning this, he said: "Oh, but there must be some terrible trouble there. My own doctor told me so. I asked him why I was feeling so bad and he answered: 'Well, you never know with head injuries. Your head is like an orange; you can squeeze the inside of it into pulp and the outside looks quite undamaged. The outside of your head looks all right.' Since then," the patient added naïvely, "I have been much worse." Now this admission showed not only an extraordinary lack of skill on the part of the doctor, but a tendency on the patient's part to be preoccupied with fears of harm to his body. Up until this time the patient had assumed that the accident had directly caused his symptoms, but as he was stimulated to think clearly about the course of the illness he was surprised to remember that he had felt none of his nervous symptoms until he had been a day or two in hospital. Immediately after his accident he had felt comparatively well and had protested against going into hospital, but the house surgeon who had examined him, fearing no doubt that he might have had a fractured skull, insisted that he regard himself as having been seriously injured. He predicted, for instance, that the patient would feel dizzy if he sat up; the patient immediately did so, duly felt light headed, and quickly lay down again. Thus he entered hospital in a faintly uneasy state of mind. No real symptoms of anxiety appeared, however, until a severely injured patient was admitted to the bed next to his. The patient immediately got into a panic, pretended that he had recovered, and got permission to go home. Only when he had told me this did he confess that he had always secretly been afraid of

illness and injury. He then went on to confess that he also had been afraid of heights, and once or twice had collapsed and had to be assisted from stagings.

Here, then, was a man holding at bay his secret fears and continuing at his work only because he was driven by the greater fear of losing "face" and becoming unemployed. Suddenly with the breaking of the scaffolding his long pent up fears became real. Actually the fall was less dreadful than he had pictured it in phantasy, but his subsequent experiences at the hands of his doctors and in hospital revived his fears of illness and injury and broke his resistance completely. Yet with psychological treatment this man was happily back at work within a month, and has remained well since.

In a case such as this it might be argued that this man would have had no hypochondriacal anxiety and no fear of returning to his work had he not had a pre-existing fear of heights and injury and that he was not therefore entitled to compensation. The law is, however, that an employer engages a worker as he is, and if he develops a neurosis which is caused partly by a predisposition and partly by the shock, physical or emotional, of an accident, the employer, being liable for the latter, is *ipso facto* liable for the disablement. It is only when there is a great disproportion between one factor and another that legal judgment must be made.

PHOBIAS

This brings us to consider the nature of phobias, that is, fears which occur in the absence of immediate danger. The difficulty of settling actions for damages or compensation is great where the incapacity after an injury consists of a phobia. For example, a man is knocked down by a motor car, recovers from his physical injuries, but remains incapable of returning to his work because he is afraid to travel in a vehicle or walk through traffic. Another type of case is that in which the claimant himself is not involved in the accident but receives a shock from witnessing its occurrence. For example, a young girl was taking her little brother for a walk; he escaped from her grasp, ran into the road and was knocked down by a motor car. The boy was little hurt, but his sister got so great a shock that she developed an anxiety state and was unable to go to her work for several months. Her parents wished to claim damages for her incapacity.

Such cases invite the obvious questions. Is the fear pathological and, if it is due to an accident, is the sufferer entitled to compen-

sation? Fear of specific external situations is a highly useful, protective emotion which is partly instinctive and partly the result of painful experience. It might be claimed that the workman, once having fallen from a height, is acting in a perfectly normal manner when he finds himself too much afraid to continue his work, on the principle of "once bitten, twice shy". This may be a reasonable theory, but in practice it seldom applies. Some people remain reckless despite, for example, terrifying experiences in air-raids, others become excessively cautious. Other fears are obsessional, that is, the individual is overcome with terror even though his reason tells him that he has nothing to fear. In other instances the emotional reaction is out of all proportion to the degree or expectation of danger. There are other cases in which a workman has many falls and returns unperturbed on each occasion to his work. But the next time he falls he may develop an acute fear of heights for no reason that he can determine.

This emphasises the importance of making a careful study not only of the nature of the accident and the patient's subsequent symptoms but also of his previous experience, temperament and personality. A careful medical history will generally show that pathological fears arise only in cases where some psychogenic factor exists at the time or is superimposed subsequent to the accident, or that the individual has a latent or actual predisposition to neurotic reaction. Such matters must be clarified not only to ensure that justice is done to the parties claiming compensation, but because they form the basis of psychological treatment.

ANXIETY NEUROSIS

We have seen that phobias are unmotivated fears of specific situations or objects, and that they throw the patient into a state of anxiety. Phobic states can, in fact, be regarded as specific manifestations or sub-divisions of anxiety neuroses proper. An anxiety neurosis is a very serious disorder which is characterised by a constant vague fear, exacerbated into attacks of panic without obvious cause, or from causes which would not be sufficient to cause anxiety in a normal person and which the patient himself often recognises as being inadequate. In addition to these fears, the patient has many psychosomatic symptoms, such as palpitation, trembling, sweating, fainting and the like. An anxiety neurosis always has its roots in the early experiences and development of

the individual and can only be relieved by psychotherapeutic investigation.

Much of what has been said about phobias in relation to compensation also applies to the anxiety neurosis. We must first distinguish from the normal anxiety which the average workman feels after injury and an anxiety neurosis proper. Anxiety of the normal type is bound to occur in a disabled workman, for his most precious possession, his health, has been threatened, perhaps permanently, and this constitutes, to himself and his family, a threat which is very real. The reduction in pay from his normal wage to thirty shillings weekly, which is the maximum disablement allowance made under the Act, means using up his savings or semi-starvation for his household. Even this meagre allowance may be further reduced when he is certified fit for "light work". He tries to get work, but who will employ him in his disabled or semi-disabled condition? He becomes tense, irritable, sleepless, or, if he loses hope, listless, soured and indifferent. Such a state is unfortunately only too common; it is painful and serious, but it is not an anxiety neurosis. It is caused by an obvious and very real environmental threat to security; it would never occur if injured workmen were relieved of material anxiety, if they got proper rehabilitation treatment and were assured of employment in the future.

Now, because this normal type of anxiety can be relieved by suitable work and economic security, a regrettable fallacy has crept into the attitude of doctors and lawyers towards neurosis cases. They see that the patient suffers from anxiety, mistake it for normal worry over his position, and think that he will be cured by work. This not only implies that a neurosis is something akin to laziness, or at least faint reluctance "to do an honest day's work", but confuses the condition with a consciously determined attitude of mind. Even patients themselves have been fooled into believing that work would cure them. Nothing is further from the truth. A neurosis can be cured only by psychotherapy and any neurotic who recovers dramatically when reinstated in his old job has been misdiagnosed. A similarly false belief, so strong in some judges and doctors as to be delusional in character, is that a lump sum settlement will promptly effect a cure. This belief is never held, however, by those who have to treat patients who have been foolish enough to accept a lump sum. Again, cases which improve dramatically in this way should be gravely suspected of malingering or at least exaggerating their symptoms. Much injustice has been

done both to employers and workmen by these two misconceptions.

HYSTERIA

Although a true anxiety neurosis is a rather uncommon result of compensation situations, hysteria is by far the commonest psychopathic reaction. Ramsay (1939) estimates that hysteria accounts for 62 per cent. of neuroses following injury. Not that the term is often used in courts of law, for the lay public still think that hysteria is akin to a violently uncontrolled emotional state, best cured by slapping the patient's face, or something in the nature of those polite vapours which our grandmothers are alleged to have affected. The courts, in fact, behave just as hysterically as the patient in that they concentrate all their attention on the physical manifestation—the paralysed limb or the area of anaesthesia—of the underlying mental disorder, which is hardly noted. This was so in a case of a shepherd who was injured at his work and developed a hysterical paralysis and anaesthesia of the left hand. The long legal skirmishing in this case revolved round the question of the extent to which the patient was disabled for work and completely ignored his neurosis. The true explanation was that, ten years previously, this man had fallen down a cliff, had been rescued in dramatic circumstances, and was regarded by the press as a local hero. When he came into my ward for examination, I found the greatest difficulty in keeping his attention on the current injury, for he much preferred showing me the press cuttings of his "crowded hour of glorious life". His second accident merely provided a vehicle for the expression of a mental state which had existed for many years.

The physical symptom in hysteria expresses, usually in symbolic form, an unconscious need or wish. Thus the soldier wishing unconsciously release from the danger of battle, and desiring at the same time to maintain his self respect and the approval of his comrades, obtains a solution to his endopsychic conflict by developing a paralysis of his legs. A quite conscious wish may concomitantly be gratified by a hysterical state. This was shown clearly in the case of a workman who developed a hysterical paralysis of a hand after a burning accident. He saw nothing incongruous in his naïve complaint that the victim of a motor accident in the next bed should be offered £1500 damages while he was offered a mere £150. But those who fail to understand the hysterical state are apt

to seize on such an admission as the sole cause of the symptoms. Here again we must note that in many cases the workman would much rather be back at work, as in the above case where the patient had previously earned £7 per week and was much worried by the difficulty of supporting a large family on his compensation allowance. We must reiterate too that payment of a lump sum does not necessarily cure the condition. This is especially so because many cases drag on for months and perhaps years. The initial cause of the delay may have been a mistaken diagnosis on the part of his own doctor who had assumed that the symptoms were caused by the physical injury and shock of the accident. At length he realises that no physical condition could linger so long unchanged; vaguely irritated because he finds himself out of his depth in dealing with functional cases, he advises or agrees with the proposal that compensation should be reduced or stopped. The patient protests, and, after examination by various medical experts, the case is brought to court. The patient wins his case because the disability directly followed the injury and, so long as malingering is not alleged, it does not matter whether the disablement is functional or organic in origin. If there had been no accident, there would have been no inability to use the limb, and so the patient should receive compensation as long as the condition exists. Even then it is seldom suggested that the essential condition of hysteria be treated. So the case drags on. Good results can only be obtained when psychotherapy is undertaken at once. Just as in fracture cases movement of the injured limb should begin at once, so psychological treatment should begin immediately after the accident. This will be referred to in greater detail later.

NEURASTHENIA

Although the diagnosis of "traumatic neurasthenia" is frequently made, true neurasthenia is a rare disease. Ramsay (1939) quotes the figure of 10 per cent., but it is probably even more uncommon. This disorder is characterised by an overwhelming sense of physical and mental fatigue. It is thus frequently confused with cases of mild depression or anxiety states in schizoid personalities. The neurasthenic, unlike the depressive, retains an interest in the outside world and bewails his inability to lead a more active life. Further, it is the listener who first shows signs of fatigue when the patient is engaged in an account of his illness.

POST-CONCUSSIONAL SYNDROME

Although it is somewhat unusual to find in civil life that claims are disputed where there has been a definite head injury it is obviously important to make a differential diagnosis between post contusion syndromes and neuroses following head injury. This is especially true in service patients and in cases coming under the Personal Injuries (Emergency Provisions) Act because compensation is only payable for disablement caused by physical injury. In every case, however, the prognosis and treatment will be radically different, consequently a brief summary of the differentiation between the two groups should be helpful.

The contusion case gives a history of a blow on the head followed by loss of consciousness. This, as Symonds (1941) points out, may have been brief or non existent, nor is there any constant relation between the degree or duration of unconsciousness to the severity and duration of the symptoms. A retrograde amnesia is almost always present. The clinical picture is one of headache, exaggerated by bending, change of posture, coughing, or by mental or physical effort. The headache is the most constant and crippling symptom and some patients complain of little else. Vertigo also occurs on change of posture or sudden movement. The patient complains that he is irritated easily, very often by noise, and that he is "unlike himself in the home". Another cardinal symptom is mild confusion; the patient complaining that he cannot concentrate on reading, that he is forgetful, or that his memory is definitely impaired. None the less the contused patient makes a much more workmanlike job of describing his symptoms, and is more optimistic about his progress.

The neurotic patient who has had a head injury, on the other hand, seldom can give a history of complete loss of consciousness, though some allege that they have been "unconscious" for several days; but close enquiry shows that they mean that they were dazed and confused for that time. Amnesia is rare; indeed, patients complain that they cannot get the memory of the horrible experience out of their minds. The neurotic does not put headache forward as the most important symptom, but he may complain of an unbearable pain in the head. When he describes this pain more fully it is evident that he uses the word "pain" for want of any better means of conveying the idea that he has head sensations of

an unbearable nature—parasthesias, tight bands, feelings of pressure, etc. The “headache” is not made worse by changes of posture, etc., and if he is giddy it is not because he bends but when he gets into a panic and has fainting, giddy feelings. The neurotic may complain of an inability to concentrate, but he clearly means loss of interest rather than confusion and forgetfulness. He is also much more pessimistic in outlook and seldom has improved in three or six months. Finally, one can always get a picture of neurotic or psychopathic personality prior to the injury.

PSYCHOSES

The term “traumatic psychosis” is almost exclusively applied to insanity following actual injury to the brain. It is a rare condition. Henderson and Gillespie (1932) quote May’s calculation of 0·3 per cent. as being traumatic psychoses of 70,989 first admissions to mental hospitals in U.S.A. Mayer says: “Even in the four cases of primary traumatic disorders, *i.e.* those which followed the injury immediately, constitutional peculiarity exists in two and alcoholism in one.” On the other hand, Brend (1938) points out that it is exceedingly difficult for a medical witness to support the opinion that a psychosis appearing after an accident is not primarily due to the injury. Statistics are inadmissible and generalisations have little influence on the court. Even distress over the probable loss of a job has been held to be an adequate cause of insanity. Thus injustice is apt to be done to employers in such cases.

MENTAL DEFICIENCY

No claim can ever be made that injury has caused mental deficiency, because the legal definition lays down that it is a condition which exists “from birth or an early age”. Nonetheless intellectual retardation plays an important part in compensation cases in that a defective person is more likely to develop traumatic hysteria than an individual of normal mental capacity. The defective is not only naïve and suggestible, he is less able to undergo any crises in his life. Many defectives live and work as lowly but useful citizens, because they are supported by the kindness and sympathy of their families, wives, employers and neighbours. Their defect passes unnoticed so long as nothing untoward happens, but their social adaptation and competence is precarious.

Let any misfortune befall them—accident, injury, national crisis—and they become anxious, bewildered and unstable. The defective, as the author (1942) has suggested, is very prone to the cruder forms of psychological disorder. It is now apparent, for example, that many of the so-called “shell shock” cases of the last war, who were so lavishly endowed with pensions, were unrecognised defectives. The defective is only too ready to prolong the duration or exaggerate the severity of any illness, pain or injury, for, by this means, he can avoid the difficulties which are for him inherent in living in an ordinary community as a self-supporting citizen. A typical example was that of a domestic servant, aged 51, who sustained a minor injury to her hand. The wound became septic and painful, but even when it had healed completely she said she was too frightened of hurting herself to move it. The hand stiffened up and two years later it was still useless. During this time she had been living in her native rural district and was passing rich on the thirty shillings weekly she received as compensation. Her mental age was just ten years.

The defective's ill developed mind is only one of the stigmata of degeneration; he has an inferior physique and poor resistance to disease also. They haunt hospital out patient departments year after year receiving treatment for defective vision, fallen arches, skin and stomach trouble, dental caries and a thousand and one other diseases. They lack the intelligence to buy and cook an adequate diet, so they and their families suffer from malnutrition. And when they are injured at work they have neither the physical nor mental stamina to make a rapid or adequate recovery.

It seems reasonable to suggest, therefore, that all compensation cases should be examined psychologically. This simple procedure would save employers and insurance companies many thousands of pounds annually, for the treatment and rehabilitation of the defective, to be successful, should differ radically from that of a normally intelligent person.

TREATMENT

The key note of the treatment of all cases of injury should be full investigation, accurate diagnosis and immediate commencement of treatment. If this programme were carried out only a small percentage of the neuroses which are constantly occurring to-day would develop. As things are, the neurosis is only recognised

months and perhaps years after the injury, and by that time treatment has to labour under a heavy handicap. Even when a neurosis is recognised it may be impossible to obtain the necessary psychiatric help. This is a serious state of affairs not only for the patient but for industry and national resources. The number of compensation cases in seven great British industries is about 500,000 a year. Putting the incidence of neuroses at 2 per cent. (and some like Ramsay (1939) put it at 41 per cent.) there would be 10,000 cases per annum. In compensation payments alone they would receive some £1,000,000 a year. What that annual figure would be if one added to it the loss to industry in working hours, the cost of legal actions, administration, etc., is impossible to say. But it is absolutely certain that only a minute sum is spent on the type of psychiatric service necessary for such cases.

What might be termed prophylactic treatment should begin immediately the injured man is attended to by his own doctor. The patient has probably been frightened not only by the accident and his own injuries, but by the remarks and excitement of his workmates and onlookers. The doctor should always allay mental distress, soothe fear, and discourage any feeling of importance the patient may feel in the seriousness of the injury. The doctor should express openly as much optimism as is justified rather than maintain silence and allow the patient, or his relatives, to make their own, probably gloomy, interpretation. If the medical attendant considers the patient as a human being and does not confine his attention to the injured part alone, he will be doing much to prevent the onset of a neurosis.

From the beginning the doctor should keep in mind the possibility that the symptoms are (a) purely organic in origin: (b) neurotic, *i.e.* unconsciously determined; (c) the result of malingering, *i.e.* consciously determined. It may not always be easy to make a differential diagnosis. A careful history should be taken with a view to determining the patient's attitude to the accident, his present disabilities and his chance of recovery. A review of past health and personality will show any tendency to neurotic illness. His school and work history will give some indication of intellectual level, and if this appears low arrangements should be made to have him tested. Physical examination, X-rays and special examinations should be thorough enough to show whether the symptoms are of the nature and extent to be expected from the injury.

Malingering is very uncommon and usually is easily detected. The malingerer tends to overact his part; dislikes being examined, and is uneasy during the process; is inclined to produce any symptom which the examiner appears to expect; and seldom produces new symptoms. He plays his role only when observed. The neurotic, on the other hand, delights in examinations and openly shows his satisfaction in minute investigation of his condition. He is suggestible, but has such a multitude of symptoms to choose from that he is not eager like the malingerer to follow any lead given him. Very often the original injury gets scant attention, while the patient complains of typically neurotic manifestations like palpitations, vertigo, sleeplessness, fears, anaesthesias and the like. Further, in a true neurosis, a positive psychogenic basis will always bear a direct relationship to the patient's symptoms. A neurotic trend is almost invariably found which has previously produced subjective states analogous to those complained of subsequent to the accident.

Having decided that there is, or may be, a neurotic element, the doctor should explain to the patient which symptoms are caused by the physical injury and which are due to anxiety. The patient should, in fact, be told frankly that he is developing a neurosis. It is by no means easy to convince a patient that his symptoms, so important and real to himself, are psychogenic in origin. Much depends upon the physician's own attitude; he must show the patient that he regards functional symptoms as being as important and worthy of attention as symptoms arising from organic causes, and must show no sign of despising the patient for having them. Having gained the patient's sympathy, he can then go over the history of the illness chronologically, showing how each symptom arose either from the injury or from the patient's own attitude. This piecing together of temporal relationships gives the patient an entirely new attitude towards his illness. Whenever the doctor thinks that he has recovered physically the patient should be urged to go back to work of his own free will. He should be warned that each day he delays will make his nervous symptoms worse, and that nothing will compensate for the mental pain he will inevitably suffer. In fact, the doctor should discuss quite frankly the whole compensation situation with the patient. He should explain that while he, the patient, may consciously be eager enough to return to work, his nervous symptoms show that unconsciously he is unwilling to do so. Further, he should warn the patient that the

worry, disappointment and self-deception which inevitably occurs in compensation cases, delays and perhaps prevents recovery. In short, if the patient goes on with his case he should do so with full knowledge of the harm which may befall him. The co-operation of the patient's lawyer may also be sought, the doctor explaining that the patient is suffering from a neurosis and showing how important it is that an early settlement is obtained. Many lawyers fail to recognise how easily compensation cases develop neuroses and do not realise the need for avoiding delay. Norcross (1936) has shown, by a careful investigation of 64 neurotic injured workmen, that treatment will be rendered the more difficult and even quite ineffectual the longer the case remains undecided. Certain lawyers appear to be quite unscrupulous and delay cases for months or years, benefiting in the end much more than the unfortunate patient. It may be necessary for the doctor to advise his patient when he thinks that this is happening. What has been said applies of course mainly to incipient or very mild neurotic reactions. Where a fully developed or acute neurosis develops the patient should be sent as soon as possible for special treatment by a medical psychologist.

A word might be said about the evils of the lump-sum settlement. We have already stated that this theoretically simple method of terminating a case has no beneficial effect on the patient and does not facilitate his early return to work. In an American investigation of 64 neurotic patients, no evidence of any therapeutic benefit from a lump-sum settlement was discovered in 41, and in 6 others no conclusion could be reached. As the *British Medical Journal* (June 29, 1940) points out, the failure to achieve results expected by those responsible for this provision in the Act appears to be due to an inadequate realisation of certain fundamental principles: (1) it is the termination of the claim and not the terms of settlement that is the more important therapeutic factor in compensation cases: (2) the prospects of a lump-sum payment may induce the patient to prolong an incapacity, while failure to receive the expected amount leaves him embittered and disillusioned: (3) the primary duty of society to the injured workman is rehabilitation, not compensation. There is, in fact, a growing weight of opinion that the act should be revised so as to discontinue this method of terminating a case. It should be remembered that the Ministry of Pensions used to urge this method in dealing with discharged soldiers suffering from neuroses, but the

policy was abandoned when it was found that the therapeutic effect was poor. Possibly employers would have given up this method also had they been dependent on re-employing those who had received lump sums.

Return to work is itself a huge problem under present conditions. Even if the patient has thoroughly recovered and returns to his former employment he may find himself discharged at the end of a week, because certain unscrupulous firms make a practice of discharging on fictitious grounds any workman who has had an accident and has received compensation. No firm will ever admit this practice, so we can only speculate that certain employers believe that a workman who was injured is *ipso facto* more prone to further injury or in some way less adequate an employee. Even if the firm does not adopt this pernicious practice the workman may be afraid of returning to work lest it prove too much for him and he finds himself discharged in favour of someone more robust.

The state of those certified for "light work" is even sadder. To begin with, many doctors give such a certificate without having any idea of what type of light work the man is capable of performing; nor have practitioners been given any guide by the Act as to what light work means. Under present conditions, too, it is most difficult for a convalescent worker to obtain such work, for there are thousands already waiting for it. This is, of course, a social rather than a medical matter, but if the employment of disabled ex-service men has been a success and if the experience of certain works in America which prefer to employ disabled men for certain processes is true, surely some more adequate provision could be made for the re-employment of convalescent and partly disabled workmen in this country. It may be that the new Government Rehabilitation Scheme (1941), which now applies to civilian as well as Service cases, will do much to solve this most difficult problem.

There are grounds, too, for believing that the maximum monetary compensation a workman may receive is too low. Ideally the sum he receives should be sufficient to meet not only his basic needs but also any increased expenditure he may have consequent on his accident. At present he receives a sum usually far below his usual weekly wage and in consequence he is immediately involved in financial worry which may delay his recovery. Besides, as Griffiths (1938) shows, "one of the most potent causes of delayed union of fractures and of prolonged incapacity for work is found

to be undernourishment." He advises feeding such cases at the hospital outpatient department. But if the patient is undernourished, his family almost certainly is so too, and no legislation should exist which should so endanger the health of the future generation. My own opinion is that the injured man should receive the same sum in compensation as he received in weekly wages. It is a mistake to think that many would be encouraged in laziness and malingering and, if this did occur, it could readily be controlled by regular medical examinations of an independent type.

Further, the injured man is not entitled to any medical treatment other than the facilities provided under the National Health Insurance Acts. It is surely desirable that he should receive as the British Medical Association (1940) advises "as soon as possible and for as long as may be necessary, such special advice and treatment as are appropriate to his disabled condition". For difficulty in obtaining any special treatment will both embitter the patient and make him more liable to neurotic reactions.

CONCLUSION

To sum up this chapter we can say that, following serious accidental injury, we find a few cases who are merely suffering from physical injury, a majority who present a combination of physical and psychological trauma, and some whose disability is purely psychiatric. These in the first category do not concern us here; nor do they present a difficult problem for their physical recovery is as rapid as possible, and they adapt themselves readily to their residual handicaps. Those in the second category are mentally stable individuals who are temporarily upset by the emotional shock of the accident and by the subsequent worry regarding financial and economic matters. Their anxiety is natural and rational, and they can be restored to normal balance if they are freed from financial strain, given adequate treatment, and rehabilitated successfully. The Ministry of Labour and National Service Interim Scheme for the Training and Resettlement of Disabled Persons (1941) is designed to meet the needs of this large class, and is already proving its usefulness. The fears and anxieties of the third class are irrational and cannot be resolved, though they may in part be relieved, by the removal of actual grounds for worry. The problem which these patients present is highly com-

plex and only partly understood at present. Experience has shown, however, that they can be successfully treated and rehabilitated if they are recognised at an early stage, and receive appropriate psychotherapy. If no special provision is made for them they rapidly lapse into a state of what Wilson (1942) calls "suicidal compromise", in which "these patients regard a living death with less distaste than normal persons do", and from which it is virtually impossible to persuade them

"to take arms against a sea of troubles,
And by opposing end them."

LIST OF REFERENCES

- BREND, W. A. *Traumatic Mental Disorders in Courts of Law*. Heineman. London, 1938.
- BREND, W. A. *British Medical Journal*. June 14th, 1941, p. 885.
- BRITISH MEDICAL ASSOCIATION. *Report of Committee on Mental Health*. London, 1941.
- BRITISH MEDICAL JOURNAL. *Supplement*. June 29, 1940, p. 1857.
- GRIFFITHS, H. E. *Post Graduate Medical Journal*. June, 1938.
- HENDERSON and GILLESPIE. *Textbook of Psychiatry*. 3rd edition, p. 349. Oxford, 1932.
- MACCALMAN, D. R. *Psychotherapy in General Practice. Textbook of Treatment*. 2nd edition, p. 1028. Livingstone, Edinburgh, 1940.
- MACCALMAN, D. R. *The Practitioner*. July, 1942. Vol. CXLIX, pp. 27-33.
- MINISTRY OF LABOUR AND NATIONAL SERVICE (1941). *Interim Scheme for the Training and Resettlement of Disabled Persons*. P.L. 93/1941.
- NORCROSS, C. *Vocational Rehabilitation and Workmen's Compensation*. Rehabilitation Clinic. New York City. 1936.
- OSLER. *Principles and Practice of Medicine*. 13th edition. 1938.
- RAMSAY, J. *British Medical Journal*. Aug. 19th, 1939. p. 385
- SUTHERLAND, J. D. *British Medical Journal*. Sept. 13th, 1941, p. 365.
- WILSON, H. *British Medical Journal*. Jan. 3rd, 1942.

VII

PHYSICAL FACTORS AND CRIMINAL BEHAVIOUR

By DR. W. NORWOOD EAST

I. INTRODUCTION

THE so-called classical school of penology is associated with the name of Cesare Beccaria, the Italian publicist, who in 1764 published his famous treatise *Dei Delitti e delle Pene* ("On Crimes and Punishments"). His humane ideas directly influenced reforming action on the Continent, and Voltaire contributed an anonymous preface to Morellet's French translation of Beccaria's pamphlet.

In England Romilly, who laboured to reform the cruel and illogical criminal law of his time, and Jeremy Bentham, who severely criticised the state of the law also and whose theories upon legal subjects influenced legislation in his own and other countries, advocated Beccaria's views. The prevention of crime rather than punishment and the prompt application of punishment when it is inevitable were recommended, whilst confiscation, torture and capital punishment were condemned.

The classical school considered that criminal conduct was chosen by the offender after a careful examination of its prospective advantages and disadvantages, and that no more punishment was necessary to check crime than would render the assumed advantages unattractive.

The neo-classical school which followed advocated the recognition of varying degrees of moral and legal responsibility as well as of mitigating circumstances. The necessity to treat the offender rather than his offence is a development of the fundamental principle of this school, which insisted upon the punishment of the individual rather than of his crime.

The positive school was a still later product. It held the criminal to be predestined to a criminal career on account of his inherited traits and that he was therefore wholly irresponsible. Although society must be protected from his criminal behaviour, the positivists considered it was wrong and foolish to punish the criminal as if he were a free agent and able to select his course of

conduct. This school aimed at the positive methods of science, and although many of the assumptions and alleged facts upon which its conclusions were based are no longer accepted by the modern school, which has arisen during the last quarter-century, a brief reference is due to some of its apostles.

The discoveries of Francis Joseph Gall in the anatomy of the brain will remain for all time of outstanding importance, and it is to be remembered, as the late Sir Henry Head pointed out in the Hughlings Jackson Lecture for 1920, that the idea that the underlying structure of the brain has an effect upon the formation of the skull, and in consequence that character could be foretold from the external conformation of the head, is only a small part of the theory put forward by Gall.

It is, indeed, tragic that Gall's scientific work is remembered for its mistakes rather than for its great achievements.

Although Gall mapped out on the skull organs of murder and theft, his co-worker, Spurzheim, and his disciple Combe modified the nomenclature in order to avoid discredit to the system.

In an article published in the *Transactions of the Phrenological Society* in 1824, Combe referred to the discovery by Gall that the size of the particular portions of the brain bears a relation to the energy of particular mental powers and dispositions. He stated that the phrenologist produces the actual skull of the criminal, or a cast of it, as evidence of the development, and proves the one exhibited to be authentic and genuine. Having done so, he specifies the development of organs which it indicates. If the skull shows that Combateness and Destructiveness and Acquisitiveness are large, but Benevolence and Conscientiousness small, and the trial shows that the criminal was an unprincipled thief and an obvious murderer, he draws the conclusion that the organs and dispositions correspond, and that he is entitled to represent the case as additional proof that these parts of the brain are connected with the tendencies ascribed to them in the phrenological system. Combe believed that if the real cause of human offences was excessive size and activity of the organs of the "animal propensities" it followed that mere punishment could not abolish crime, because it overlooked the cause and left it to operate with unabated energy after the infliction had been endured.

Although anatomy, physiology, psychology and experience discredit to-day the phrenological diagnosis of character, the criminologist remains indebted to Gall and his followers. For they

called attention to the importance of the study of the individual offender, and to the fact that criminal legislation and prison discipline must be based upon scientific data in order to be effective.

Gall's observations on the cranial formation of criminals induced Lauvergne to study the convicts of Toulon. He considered the assassins presented "a peculiar face stamped by a seal of a brutal and impassable instinct. Their heads were large and receding with notable lateral protuberances, enormous faces, and masticatory muscles always in motion". A year before Carus stated that delinquents were to be distinguished by a narrow forehead, the insufficient development of the occiput, and the length of the cranium.

Among the criminologists of the latter half of the last century Lombroso held a foremost place. His anthropological investigations of criminals appear to have arisen accidentally from his discovery of anomalies in the skull of a brigand. In a statement before the Congress of Criminal Anthropology held in Turin in 1906, he described how ". . . at the sight of these strange anomalies as a large plain appears under an inflamed horizon, the problem of the nature and origin of the criminal seemed to me resolved; the character of primitive men and of inferior animals must be reproduced in our time".

As a result of a study of 383 skulls of criminals Lombroso found certain anomalies present which he believed to be more marked in criminals than in the insane. He considered that a comparison with savage and prehistoric skulls showed the atavistic character of some of the anomalies. He says: "Is it possible that individuals afflicted with so great a number of alterations should have the same sentiments as men with a skull entirely normal? And note that these cranial alterations bear only upon the most visible modifications of the intellectual centre, the alterations of volume and of form." His anthropometric and physiognomic observations were the result of the examination by himself and other criminologists of 5,907 criminals. In regard to the former he says: "The study of the living, in short, confirms, although less exactly and less constantly, this frequency of microcephalies, asymmetries, of oblique orbits, of prognathisms, of frontal sinuses developed as the anatomical table has shown us. It shows new analogies between the insane, savages and criminals. The prognathism, the hair abundant, black and frizzled, the sparse beard, the skin very often brown, the oxycephaly, the oblique eyes, the small skull, the de-

veloped jaw and zygomas, the retreating forehead, the voluminous ears, the analogy between the two sexes, a greater reach, are new characteristics added to the characteristics observed in the dead which bring the European criminals nearer to the Australian and Mongolian type; while the strabism, the cranial asymmetries and the serious histological anomalies, the osteomates, the meningitic lesions, hepatic and cardiac also show us in the criminal a man abnormal before his birth, by arrest of development or by disease acquired from different organs, above all, from the nervous centres as in the insane; and make him a person who is chronically ill."

Referring to the physiognomy of the criminal he states: "In general, many criminals have outstanding ears, abundant hair, a sparse beard, enormous frontal sinuses and jaws, a square and projecting chin, broad cheekbones, frequent gestures, in fact, a type resembling the Mongolian and sometimes the negro."

Lombroso believed that his anatomical studies enabled him to distinguish the criminal he believed to be born as such from the criminal of habit, passion or occasion whom he believed to be born with very few or no abnormal characteristics. He believed in the identity of the "born criminal" and "moral imbecile" and also demonstrated many similarities between the former and the epileptic in height and weight, the brain and skull, the physiognomy, the flat and prehensile foot, the sensibility, the visual field, motility, tattooing, etc. (Parmelee). And he finds "Criminality is therefore an atavistic phenomenon which is provoked by morbid causes of which the fundamental manifestation is epilepsy".

In a later volume, *Crime, Its Causes and Remedies*, Lombroso wrote the complement to his study on Criminal Man, from which the above extracts are taken, and refuted the accusation that his school neglected the social and economic causes of crime. He states in his preface to the later work "that certain practical nations, less smothered than our own under a too glorious past, and for that reason less infatuated with the ancient codes, have already here and there arrived empirically, without knowing a word of criminal anthropology, at several of the reforms that I shall suggest. The asylum for the criminal insane, the truant schools, the ragged schools, the societies for the protection of children and the asylums for alcoholics, and institutions which, without being a part of the criminal code, have been applied more or less completely in North America, England and Switzerland. . . ."

Francis Galton, as a result of his investigations into physiological types, by the method of composite portraiture, found the individual faces seen in official photographs of criminals were villainous in different ways, and when they were combined the individual peculiarities disappeared leaving only "the common humanity of a low type". Even as late as 1914 Havelock Ellis agreed with the statement made by Hepworth Dixon in 1850, that the criminal countenance was at once repulsive and interesting.

Havelock Ellis reproduced a series of thirty imaginative portraits from the note books of Vans Clarke, a former medical officer of Pentonville prison. The artist stated that the portraits were necessarily taken in haste, but they were true and were considered to be successful likenesses. Later, Charles Goring, when medical officer at Parkhurst prison, compared them with a series of thirty photographic outline profiles traced by him from a series of photographs selected at random from the official portraits of convicts at Parkhurst. Goring's composite portrait suggests the ordinary citizen; the composite imaginative portrait resulting from the drawings of Vans Clarke favours imbecility.

On my introduction to prison medical work at the commencement of the present century, I was impressed by the unattractive facial appearance of the convicts at Portland prison and attributed it to their criminality. In later years experience proved this view to be mainly incorrect, and the unattractiveness to be due to four chief causes. One of these disappeared when the Mental Deficiency Act, 1913, came into operation, and withdrew from the prison population an appreciable number of mentally defective persons. Further improvement was observed as soon as prisoners were allowed to grow their hair instead of having it cut close to the scalp with clippers. Betterment increased when the broad arrow stamp was discarded and the ungainly uniform of the prisoners was altered and approximated to ordinary civilian clothing. Perhaps the greatest change was observed when the harsh penal discipline was replaced by humane understanding, for the facial expressions of many prisoners altered when they were no longer treated as criminals to be suppressed, but as men and women whose co-operation was necessary for their reformation.

I have stated elsewhere that the student of criminal physiognomy is rightly concerned with more than mere facial and cranial outlines. For if we accept modern psychological teaching that the instincts with their accompanying emotions form the basis of

character and temperament and thereby affect human conduct, and if we consider that the emotional reaction is reflected in part by an alteration of facial expression, we can believe that permanent and characteristic changes will be engraved upon the features by a frequently repeated emotion, or its corresponding mood if long continued. There can be little doubt that in certain cases the facial expression so impressed may suggest the nature of the crime and the habit of the criminal. But it is a suggestion only. For although everyday experience tends to show that some observers are particularly gifted in the accurate interpretation of the facial expressions of casual acquaintances, estimations of character, by this means, in any series of criminal cases, are so frequently at fault as to be quite unreliable unless corroborated by ascertained facts.

2. ANTHROPOMETRICAL RESEARCH

During the first decade of the present century seven medical officers of the Prison Service of England and Wales carried out a series of anthropometrical measurements in the convict prisons. Service conditions enabled Charles Goring to examine a larger number of men for this purpose than any other one of us in the team, and he was eminently suited to collate the material. This he did between May, 1909 and November, 1911, in the Biometric Laboratory of University College, London, under Professor Karl Pearson, and the results were published in 1913.

Goring summarised the results of this inquiry into the physical characters of criminals thus: "We have exhaustively compared, with regard to many physical characters, different kinds of criminals with each other, and criminals as a class with the law-abiding public. From these comparisons, no evidence has emerged confirming the existence of a physical criminal type, such as Lombroso and his disciples have described. Our data do show that physical differences exist between different kinds of criminals: precisely as they exist between different kinds of law-abiding people. But when allowance is made for a certain range of probable variation, and when they are reduced to a common standard of age, stature, intelligence and class, etc., these differences tend entirely to disappear. Our results nowhere confirm the evidence nor justify the allegations of criminal anthropologists. They challenge their evidence at almost every point. In fact, both with regard to measurements and the presence of physical anomalies in

criminals, our statistics present a startling conformity with similar statistics of the law-abiding classes. The final conclusion we are bound to accept until further evidence in the train of long series of statistics, may compel us to reject or modify an apparent certainty—our inevitable conclusion must be that there is no such thing as a physical criminal type.”

Goring believed that “the tendency to be convicted and imprisoned for crime is influenced by the force of heredity in much the same way, and to much the same extent, as are physical and mental qualities and conditions in man”.

Earnest Albert Hooton is the most recent critic of Goring's work. In his anthropological study of *The American Criminal*, Hooton states: “There are many portions of Goring's work which are of great value. His notable contributions are in the study of criminal physique which he finds definitely inferior, thus confirming the conclusions of Lombroso, in the influence of age upon crime, in the vital statistics of the criminal, in the mental differentiation of the criminal (which again agrees with Lombrosian ideas), and in his investigations of ‘force of circumstances’, fertility and heredity. He cannot be denied great credit for his painstaking investigation of these important aspects of crime. He also deserves abundant praise for the variety of delicate and ingenuous statistical devices he employs, although his method of using them is frequently culpable.

“In his efforts to disprove physical differentiation of the criminal Goring displays most of the faults which he charges to Lombroso, and others of which Lombroso was never guilty. In an early stage of Goring's work, Professor Karl Pearson asked him the question, ‘And what if Lombroso's theory be established by your analysis?’ ‘I shall accept it as the foundation of criminology, but shall none the less condemn Lombroso as a traitor to science.’ Professor Pearson quotes this reply with apparent approbation, but it seems to the present writer (Hooton) to epitomise the lack of an objective viewpoint and the prejudice which inevitably vitiate the work of the scientist who approaches his task with an emotional preconception of its issue. Actually Goring left the problem of the relation of the criminal's physique to his offence unsolved. Mathematical formulæ and verbal sophistries may befuddle lay readers, but no one who reads and understands Goring's *English Convict* can accept his conclusions until he shares the prejudice of the author.” It is not my intention to criticise

Goring's work here. It must always be remembered that he was dealing with a limited class of prisoners—recidivists and others convicted of serious crimes.

F. E. E. Schneider, when medical officer at Pentonville Prison, estimated the vital capacity of 600 adult recidivists on reception into and discharge from that prison. The results led him to conclude, within the limits of the investigation, that the vitality or health of the average criminal recidivist is not much below that of other men, that his health improved in favourable surroundings, which implied that his surroundings were not favourable when he committed the offence, and that imprisonment had a beneficial effect on his health.

Hooton states: "Criminals are inferior to civilians in nearly all of their bodily measurements. These differences attain statistical significance and general criminological validity in body-weight, in stature, in biacromial breadth, chest depth, chest breadth, cranial circumference, nose height, ear length, head height and upper facial height. Criminals also diverge from civilians in having higher fronto-parietal indices, lower facial indices, higher nasal indices, higher zygo-frontal indices and greater relative sitting height. These differences appear to be independent of age and state sampling.

He declares that several outstanding morphological differences exist between criminals and civilians. For example, we are told that tattooing is commoner among criminals than among civilians, that criminals probably have thinner beard and body hair and thicker head hair; that criminals have more straight hair and less curved hair and have more red-brown hair and less grey and white hair. That low and sloping foreheads, thin lips and compressed jaw angles are commoner in criminals than in civilians, and so on.

Hooton believes that his information definitely proves that it is from the physically inferior element of the American population that native born criminals of native parentage are mainly derived. He says: "My present hypothesis is that physical inferiority is of principally hereditary origin; that these hereditary inferiors naturally gravitate into unfavourable environmental conditions; and that the worst or weakest of them yield to social stresses which force them into criminal behaviour." He recognises, however, that the results of his investigation, so far, cannot be said to have any great practical utility. In *Crime and The Man* Hooton points

out that "No one . . . would conceive it possible to utilise for purposes of practical criminal diagnosis any rigid multiple combination of morphological features supposed to constitute a criminal type. . . . All that can be expected of the . . . typing of criminals is that excesses of this kind or that kind of offence may be demonstrated for the several sub-groups."

Frank A. Ross, reviewing Hooton's anthropological study, states: "Hooton appears to have the mistaken idea that all data gathered in any fashion in jails, penitentiaries, etc., are 'sample' data in the sense that they represent the universe of the criminal. He makes brave and convincing defense of his materials and acknowledges certain flaws, even going so far as to correct some deficiencies. But in the light of present day knowledge of sampling methods his data appear to be open at points to specific challenge."

William B. Tucker summarises the objections raised by the critics of Hooton's reports on his criminological studies thus: (1) Hooton did not take non-physical factors into account sufficiently; (2) his assumption that incarcerated criminals are representative of all criminals is untenable; (3) his controls were inadequate; and (4) some of his statistics are open to challenge

With regard to the first of these objections Tucker points out that Hooton deliberately chose not to study the non-physical basis of crime, leaving that aspect to the sociologists and criminologists. Concerning the second, Tucker calls attention to the fact that there is some evidence that prison samples are not characteristic of all criminals, but this is a practical problem which is difficult to overcome when one wishes to study a group of criminals, and lacking the perfect group to be studied it may not be unwarranted to accept tentatively the representativeness of the prison group. In regard to the inadequacy of Hooton's controls, Tucker considers the objection does not pay enough attention to the fact that a total of 3,203 non-criminals were employed in the analysis. He also considers that careful study fails to reveal serious misuse by Hooton of statistical techniques, though the interpretations may be sometimes questioned.

Tucker says: "Making due allowances, therefore, for such relatively minor faults in Hooton's argument, it still may be conservatively stated that physical (anthropometric) differences have been demonstrated, between criminals and non-criminals, but especially among offence groups.

"If this position is tenable—and it seems to be, on the evidence now available—there should be no cause for concern, but rather cause for quickened interest, to follow down a lead offering greater or less promise of solving the complex cause of crime." He refers to Langfeldt's findings that leptosomes and schizothymes were the commonest physical and psychological types amongst criminals; to the work of Berry and Buchner who found a correlation between the size of the head and intelligence and found criminals to have lower brain capacity than other groups; to the anthropometric study of Illinois convicts by Gray in which the difficulty of the problem was seen in the fact that a great many of the measurements were affected by the age of the individual, and to the works of De Pina and Frassetto who advocate a more comprehensive morphological method than reliance on such indices as the cephalic or nasal index alone.

Edwin A. Sutherland in a review of Hooton's work states: "It is a monumental work in size, but unfortunately it makes little contribution to the explanation of criminal behaviour."

3. RECENT RESEARCH AMONGST ADOLESCENT OFFENDERS IN ENGLAND

During the years 1930–1936 inclusive, 4,000 adolescent offenders were examined under my direction for the purpose of statistical study at Wormwood Scrubs Boys Prison. A brief reference may be made to some of the results although the investigation was not primarily concerned with anthropometrical data.

Stature.—There was no evidence of association between repeated offences and stature. The mean height of lads with a record of offences against property and the person was greater than for the sexual and discipline¹ groups of offenders at ages 16, 17 and 19, and was not exceeded by any other group at 18, but at no age was the excess significant. The other groups did not show any significant variation either.

Weight.—There was no appreciable difference of mean weight between the first and second offenders; the excess was only apparent for those with a record of 2 or more previous convictions,

¹ The discipline group, included breach of recognisances (other than committing fresh offences), absconding from a Home Office School, some cases of wilful damage, using insulting words and behaviour, obstruction, road traffic offences, refusing labour, causing the police unnecessary trouble and Army offences, for example, mutiny.

but was not statistically significant for any age taken alone. The consistent excess in weight of lads with more than one previous offence at every age could scarcely be fortuitous and could not be accounted for by the difference in mean stature. It probably indicated a slightly better average nutrition or muscular development amongst the lads who had served several sentences, and since the first sentence is usually one of probation the excess may be accounted for by the lads having received a more carefully balanced diet during the period of detention in an Approved School or Borstal Institution.

Hooton reached the opposite view, and found that recidivists among native white prisoners of native parentage and all ages in certain prisons and reformatories in America tended to be lighter in weight than first offenders.

The lads investigated at Wormwood Scrubs were selected from the London and surrounding areas. A comparison of their mean heights and weights with the mean heights and weights found by Cathcart, Hughes and Chalmers in 1929-1932, in employed males of the same ages and mostly of the artisan class taken from London and other large towns in England and Scotland, shows no tendency for the lads convicted of crime to differ from them in stature, and there was no certain evidence of any association of criminal tendencies with underweight.

Chest Girth.—Among the Wormwood Scrubs lads a slight excess of chest girth compared with the first offenders was found in nine out of ten of the half-yearly age groups, but in no case did the excess amount to twice the standard error and only in three groups was it greater than the standard error. Lads with a record of two previous offences showed excess over the first offenders at each age, whilst those with three or more previous offences registered an excess at 16-19 years, but only at age 16 was the excess statistically significant. Hooton found that recidivists in the American criminals tended to be different in chest breadth in comparison with first offenders. When grouped according to the nature of the offences no significant differences were noted at any age in the lads at Wormwood Scrubs, nor was there any consistent tendency for any of the groups to have high or low chest measurements throughout the age scale (*i.e.* 16-21 years).

In connection with the hypothesis of physical inferiority amongst criminals accepted by Lombroso, Goring and Hooton, it may be noted that the physique of the present population in this

country has greatly benefited by modern improvements in hygiene and nutrition, and that this has chiefly affected the social groups from which most offenders are drawn. The force of environment cannot be denied.

An observation in the year 1883 by Francis Galton when he was 61 years of age is instructive. He stated: "I may be permitted to give an example bearing on the increased stature of the better housed and fed portion of the nation, in a recollection of my own as to the difference in height between myself and my fellow colleagues at Trinity College, Cambridge, in 1840-4. My height is 5 feet 9 $\frac{3}{4}$ inches, and I recollect perfectly that among the crowd of undergraduates I stood somewhat taller than the majority. I generally looked a little downward when I met their eyes. In later years, whenever I have visited Cambridge, I have lingered in the ante-chapel and repeated the comparison, and now I find myself decidedly shorter than the average of the students. I have precisely the same kind of recollection and the same present experience of the height of crowds of well-dressed persons. I used always to get a fair view of what was going on over or between their heads; I rarely can do so now."

Vision.—About 12 $\frac{1}{2}$ per cent. of the lads investigated at Wormwood Scrubs had bad or impaired vision. The proportion was rather higher at ages 19-20, but the excess over that at ages 16-18 was of doubtful significance. The group with a record of sexual offences showed a significantly higher proportion with poor vision at ages 19-20, but not at ages 16-18. Combining all kinds of offences the frequency of poor vision amongst the first offenders was rather less than amongst the repeated offenders at each age group, and significantly so at ages 18-19. The association of poor vision with multiple offences was not significant when all ages were treated together.

Hearing.—Only four per cent. of the lads had bad or impaired hearing. The proportion was significantly higher at ages 19-20 than at ages 16-18. No evidence was found of any association between impaired hearing and the number of offences.

When considering the physique of adolescents, however, it is important to remember the phenomena of occasional acceleration of growth noted by Quetelet in 1870, and of periodic variation of growth. Godin investigated the latter and observed during a period of 5 years a large number of adolescents and measured 100 of them at intervals of six months during the period and found

sudden augmentation of the increment of growth at the 15th year. His figures were supported by those of Carlier, although Quetelet's failed to exhibit a similar increase. W. L. H. Duckworth suggests that this may be due to the deliberate selection by Quetelet of his subjects. He adds that more recent researches distinguish two particular periods of growth activity in respect of stature, namely, from 5 to 7 years and from 13 to 16 years respectively, and that these two periods alternate others when circumferential growth predominates.

Further, G. E. Friend found that the school boys at Christ Hospital, Horsham, attained a maximum rate of increase in height during the spring, while that for weight occurred in the autumn. He also found that during the latter half of the period when rationing was in force during the war 1914-18, the rate of growth as measured by the height tended to slow down in the sixteenth year whereas under the more satisfactory nutritional conditions which later prevailed the retardation was not normally observed until late in the 17th year.

4. OTHER RESEARCHES

It should be added that W. Healy found poor physical condition was relatively infrequent either as a major or minor factor in the causation of delinquency. T. L. Kelly found delinquents were inferior in strength of grip and in lung capacity as compared with children of the same age. Cyril Burt found among 197 boys and girls whose ages varied from 5 to 18 years, that in 12 per cent. of the boys and 5 per cent. of the girls an excessive or inadequate development of physique figured as a probable factor in causing delinquency. Of these, the delinquent boys were commonly undersized and the delinquent girls were more usually overgrown. Burt states that the clearest instances of adolescent crime in his cases occurred when physical development was unusually early and mental and moral development retarded or delayed. He found premature or excessive sex development among nearly 10 per cent. of the girls and only 4 per cent. of the boys. In the typical case size, strength, figure and form, sexual functions and sexual consciousness were developed prematurely together. He also found that defective physical conditions were, roughly speaking, one and a quarter times as frequent among delinquent children as they were among non-delinquent children from the same schools and streets. J. Slawson

found delinquent boys to be slightly superior in weight to school children of the same ages and of comparable social status. Clairette P. Armstrong found physical defects were more numerous with runaway boys arraigned in the New York City Childrens' Court than with public school children on entering or leaving school except for vision, when there was little difference between the groups. This author considers the figures demonstrate the fact that the runaways are neglected with regard to physical hygiene as compared with the unselected child. Benjamin Frank and Paul Cleland studied a group of 504 inmates of the New Jersey State Reformatory and concluded that there was no significant relationship between physical capacity and mental level, nor between physical capacity and the type of crime committed. The evidence for a relationship between physical capacity and the number of institutional commitments was inconclusive. On all tests of force the guards were superior to the inmates, but the latter were superior to a group of guards in the same institution with respect to velocity measures.

These authors define physical capacity as the capacity of the large muscle groups to translate power, and that it is "conditioned by two factors, that of muscular force inherent in the muscle fibre and that of muscular velocity inherent in the innervation of the muscle cells. Ideally these two factors should so combine in the expression of physical power that the result is efficient movement with the least expenditure of energy". (H. L. MacCurdy).

Age may be an important factor in the causation of crime. The Criminal Statistics, 1937, show that the number of male offenders found guilty of indictable offences per 100,000 of the population is greater in the age groups fourteen and under sixteen years than in the age group ten and under fourteen years. After the age of sixteen years the rate per 100,000 shows a decrease in each successive age period. Thus in the years 1930 to 1937 the average number of offenders of the ages ten and under fourteen years per 100,000 of the population in that age group was 788; at the ages of fourteen and under sixteen years 822; at sixteen and under twenty-one years 708; at twenty-one and under thirty years 446; at thirty years and over, 171; whilst the average for all ages of the male population over the age of ten was 354 per 100,000.

Although no figures are available to show the amount of misconduct in children between the ages of 5 and 7 years such as

would constitute a legal offence if they had been aged 8 (when criminal responsibility in this country may be proved) and which might be associated with growth activity, it is perhaps significant that Duckworth's second period of growth activity, namely, from 13 to 16 years of age, corresponds with the period of most lawlessness. It would almost seem that the organism is so occupied with its physical development at this period that there is no surplus energy for social development. The problem, however, is complex. Physiological, psychological and environmental factors may all press heavily upon the individual during puberty and adolescence.

Reference has been made already to the difficulty of obtaining sample data representing the universe of criminals. Offenders in custody are not necessarily representative of all criminals, and a sample of the general population is likely to include a proportion of undetected as well as future offenders. How fallacious it may be to compare a group of criminals with a non-criminal group unless a very large number of cases are examined is seen in the fact that in the year 1938, the last for which figures are available at the time of writing, the grand total of persons in England and Wales tried for indictable or non-indictable offences was 830,184 or 20,143 per million of the population of that year, and 784,482 were found guilty. To this figure must be added an unknown number of persons who have committed crimes which are not reported to the police and others who avoid arrest although the crimes are known. In the investigation at the Boys prison no more was attempted than to compare offenders with previous convictions and those of the same ages with none.

The degree of criminality in different offence groups, or even in persons in the same group, may be quite wrongly assessed unless studies are made of individual offenders and the circumstances associated with their offences. Murder, for example, is necessarily punished more severely than theft, but the murderer who is reprieved and is not insane is unlikely to repeat his offence, whereas the criminal tendency of the thief often urges him to steal again as soon as he is at liberty. Further, experience shows the varying degrees of turpitude between one and another case of murder and between different thefts.

The anthropological school believed the criminal was irresponsible on account of faulty inheritance, the environmental school placed the blame for criminality upon the society which

allowed adverse social conditions to exist. The modern school, recognising the importance of both inherited and environmental factors, finds sometimes one and sometimes the other predominant, and since physical and mental qualities sometimes overlap in a perplexing manner a wide reference to some modern observations appears advisable.

A striking contribution to the study of the hereditary constitution of the criminal has been made by Johannes Lange in his investigation of criminal twins in Germany. His method involves an investigation into the behaviour of monozygotic twins, dizygotic twins and other siblings. Monozygotic twins are the result of fission of a single ovum and dizygotic twins develop from two separate ova and their inherited qualities are no more alike than those of siblings who are not twins. The childhood environments of both classes of twins, however, are likely to be similar. If so, and if hereditary factors dominate behaviour, a closer similarity in conduct may be expected in monozygotic than in dizygotic twins. If the hereditary factor is of little importance the criminality of pairs of monozygotic twins will show no more similarity than in pairs of dizygotic twins and the dissimilarity in the criminal behaviour of monozygotic twins will provide material which will enable the environmental factors to be assessed. Since the environmental factor will be more nearly the same in dissimilar twins than in any other pairs of siblings except mono-ovular twins whilst the hereditary endowment will be the same, differences between the behaviour of pairs of the former and pairs of the latter will tend to increase as the influence of the hereditary factor decreases. If, however, the hereditary factor is important and the environmental factor unimportant the criminal behaviour of monozygotic twins will be more alike than that of the dizygotic twins, and that of the latter will show no more similarity than is found in any other pair of siblings. In 13 monozygotic pairs of twins Lange found both twins had been sentenced for an offence in 10 cases, and in 3 cases only one twin had broken the law whilst the other had not. Of 17 dizygotic twins both twins had only been sentenced in two cases whilst in all the rest only one twin had come before the courts and the other had not. A comparison between the criminality of dizygotic twins with the criminality found in ordinary siblings showed that both of a pair of dizygotic twins were not sentenced more frequently than was expected. Lange concluded that . . . "heredity does play a role of paramount im-

portance in making the criminal. Our rough figures also permit the conclusion that heredity alone is not exclusively a cause of criminality, but that one must also allow a certain amount for environmental influences. Even our monozygotic pairs did not by any means show complete agreement in their attitudes to crime. The fact that in about one quarter of the cases only one of the monozygotic twins was sentenced must be interpreted as showing that in these cases some environmental influence or other determined the criminal behaviour."

A. J. Rosanoff, L. M. Handy and I. A. Rosanoff found in 97 pairs of twins in an adult criminality group 33 pairs of male twins who were probably monozygotic. In 22 cases both twins were criminal, in 11 only one was criminal, the other not. There were 23 pairs of dizygotic male twins in the group, and in only 3 cases were both of the twins criminal. A similar result was found for female monozygotic and dizygotic twins.

Heinrich Kranz found in 32 monozygotic twins 21 (66 per cent.) were concordant, each twin of the pair having a criminal record; and 11 (34 per cent.) were discordant. Of 43 dizygotic twins of the same sex 23 (54 per cent.) were concordant and 20 (46 per cent.) were discordant, and of 50 dizygotic twins of different sex 7 (14 per cent.) were concordant and 43 (86 per cent.) discordant. He adds, "This indicates that of the monozygotic twins, about two-thirds were concordant in respect of criminality; of the same sexed dizygotic about one half were concordant; and of the different sexed twins about one-seventh were concordant."

Friedrich Stumpfl found in a recent study that the number of criminal pairs was 11 out of 18 identical pairs, and 7 out of 19 fraternal pairs. These deductions, like those of Lange, are founded upon small numbers, but personal experience leaves one in no doubt that certain crimes are almost entirely endogenous; for example, those directly due to constitutional types of mental disorder. Others appear to be almost entirely exogenous; for example, offences committed by normal persons under the force of circumstance.

In the investigation at Wormwood Scrubs a criminal heredity was significantly associated with a history of more than one conviction in lads with a record of offences against property, and it appeared probable that for about 60 lads in the group of 3,622 a criminal family history was a causative factor in the commission of further offences after the first conviction. There was no evidence

of any association between an insane heredity and the number of convictions. The figures suggest that a family history of mental defectiveness may have been responsible for about 6 lads committing offences in the discipline and sexual groups, and that a family history of epilepsy might be considered responsible for about 8 lads committing offences in the discipline group. But I have no reason to consider from our work at Wormwood Scrubs or from personal experience over many years, that criminality, as such, is transmissible.

5. CONSTITUTION TYPES

Kretschmer's work on Physique and Character led him to consider that there is a distinct relationship between the two, and he classified the physical characteristics of some 400 men and women into four types: The asthenic or leptosome is of slight physique and is essentially deficient in thickness and of average unlesened length, the deficiency in thickness is present in all parts of the body so that the average weight as well as the total circumference and breadth measurements are below the general average for males. The athletic type is recognised by the strong development of the skeleton, musculature and skin; the height is above the average and the torso broad. The pyknic type is characterised by middle height, rounded figure, deep vaulted chest and prominent abdomen. The dysplastic type is, for the most part, undersized, in the face there is a scanty and insufficient modelling of the prominent parts of the nose, lips and chin. The bony relief of the forehead is correspondingly weak.

Kretschmer divides the temperaments into schizothymic and cyclothymic groups, and divides these into sub-groups. He considers that schizophrenic patients are derived from the former group and manic-depressives from the latter. He formulates his results thus: There is a clear biological affinity between the psychic disposition of the manic-depressives and the pyknic body type. There is a clear biological affinity between the psychic disposition of the schizophrenic and the bodily disposition characteristic of the asthenics, athletics and certain dysplastics. Vice versa, there is only a weak affinity between schizophrenic and pyknic on the one hand and between circulars and asthenics, athletics and dysplastics on the other.

E. Mezger considers the pyknic type of person, being more

sociable and adaptable, is less likely to commit crime and is more easily reformable. G. Aschaffenburg believes the pyknic type is prevalent among occasional offenders, and that the asthenic and athletic types have a larger share among habitual offenders. W. Sauer regards the tendency of the cyclothyme to be more directed towards crimes of violence, and that of the schizothyme to crimes of acquisitiveness.

Werner, S., Landecker, refers to two studies, each based on 100 cases, one published by Kurt Boehmer dealing with inmates of a German prison, the other by S. Blinkov dealing with murderers of Turkish descent in the Russian province of Aserbaidzan. In both groups the proportion of pyknics was considerably lower than that of the other types. The German study does not substantiate the assumption that pyknics commit acts of violence, the athletic type appeared to be associated with such offences. In the Russian study asthenics outnumbered any other type among the murderers.

Willemse records a series of detailed observations upon 177 delinquents in South Africa between the ages of $16\frac{1}{2}$ and $21\frac{1}{2}$ years.

Olof Kinberg found numerous leptosomes and athletics in a group of murderers examined by him, but only one pyknic. He states that pyknics are also rare among habitual criminals, but leptosomes, athletics and mixed forms are numerous. He does not, however, state the number of murderers in the group nor the proportion of pyknics to asthenics and athletics in the general population of Sweden.

Whilst it is true that some correlation between the physical and psychological constitutions can often be traced, transitional forms and mixed types, as Kretschmer points out, are frequently found. I entirely agree with Landecker's conclusion that "The thesis of an association between physique and character should be applied in the field of criminology with extreme caution. . . . There are a variety of other factors which contribute also to the formation of behaviour patterns. Science is not yet in a position to determine the share of the constitutional factors as compared with others."

6. CONCLUSION

The physician finds the behaviour of a person who is ill often differs from his behaviour when he is well, and crime may be indirectly due to a physical illness. Many important new facts are appearing as a result of investigations into the activities of the

endocrine glands; but the resulting knowledge is more impressive than its practical application in the treatment of criminals. Further, E. Mapother and Aubrey Lewis, writing in 1937, state "Evidence, still inconclusive, is accumulating to suggest that the blind use of the endocrine glands in the theory and practice of psychiatry has had its day."

As far as can be seen at present the successful treatment of criminal behaviour by means of organotherapy and hormonotherapy can only be achieved occasionally. Progress in this field, like progress in the psychological treatment of crime, is likely to be retarded and science discredited by uncritical observation.

With reference to the much debated question concerning the advisability of sterilising criminals it may be stated with confidence that no physician, biologist, eugenist or criminologist is in a position to declare that the criminality of any individual will be transmitted. And, as I have said elsewhere, amidst so much difficulty, doubt and perhaps misunderstanding, eugenic sterilisation, as a means of combating crime, appears to be unwarranted. The minor operation is inappropriate as a preventive of sex crime. The major operation may be harmful in its effect upon the individual, and may lead to a false sense of security in the public mind. At the present time there is insufficient evidence to determine its value. Both operations, as punitive expedients, are contrary to public sentiment.

Misconceptions in the past have often obscured facts, and it may be difficult to decide in individual cases whether the physical or mental condition of an offender has been predominant in causing a criminal act. Assistance in the matter may sometimes be obtained from laboratory tests; for example, an electroencephalogram may suggest an epileptic focus as the cause of a crime. We may confidently believe that better understanding will enable us in future to help society as well as the offender still further, and elucidate the complex physical, mental and other factors associated with criminal behaviour.

LIST OF REFERENCES

- ARMSTRONG, CLAIRETTE P. *660 Runaway Boys*. Boston 1932.
ASCHAFFENBURG, G. "Kriminalanthropologie und Kriminalbiologie." *Handwoerterbuch der Kriminologie*. 1933-36.

- BERRY, R. J. A. and BUCHNER, L. W. G. "The Correlation of Size of Head and Intelligence." *Proc. Roy. Soc. Victoria*. n.s. Vol. 25, 229-253. 1913.
- BLINKOV, S. "Zur Frage nach dem Körperbau des Verbrechers." *Monatssch.f.k. Psychol.* 1929.
- BOEHMER, K. "Untersuchungen über dem Körperbau des Verbrechers." *Monatssch.f.k. Psychol.* 1928.
- BURT, CYRIL *The Young Delinquent*. London 1926.
- CARUS. *Principles of a New and Scientific Craniology*. 1840. (Quoted by De Quiros.)
- COMBE, G. "On the Progress of Phrenology." *Trans. Phrenological Society*. 1824.
- DUCKWORTH, WYNFRID L. H. "Art Anthropometry." *Ency. Britt.* Edit. London, 1937.
- EAST, W. NORWOOD. *Medical Aspects of Crime*. London 1936.
- EAST, W. NORWOOD; STOCKS, P.; and YOUNG, H. T. P. *The Adolescent Criminal*. London 1942.
- ELLIS, HAVELOCK. *The Criminal*. 5th edit. London 1914.
- FRANK, B.; and CLELAND, P. "The Physical Capacity of The Young Adult Criminal." *Amer. Jour. Criminal Law and Criminology*, Vol. XXVI, No. 4. Nov., 1935.
- FRASSETTO, FABIO. "Les formes normales du crâne humain." *Bul. de la Soc. d'étude des Formes Humaines*. Nos. 3-4. Paris, 1929.
- FRIEND, G. E. *The Schoolboy: His Nutrition, Physical Development and Health*. Cambridge 1935.
- GALTON, FRANCIS. *Inquiries into Human Faculty and Its Development*. London 1883.
- GODIN. *Recherches sur la croissance des diverses parties du corps*. 1903.
- GORING, CHARLES. *The English Convict*. London 1913.
- HEALY, W. *The Individual Delinquent*. London 1915.
- HOOTON, EARNEST ALBERT. *The American Criminal*. Cambridge (Mass.) 1939.
- HOOTON, EARNEST ALBERT. *Crime and The Man*. Cambridge (Mass.) 1939.
- KELLY, T. L. "Mental Aspects of Delinquency." *U. of Tex. Bull.* March, 1917.
- KINBERG, O. *Basic Problems of Criminology*. Copenhagen and London 1935.
- KIRCHWEY, G.W. Art. "Penology." *Ency. Britt.* Edit. London 1937.
- KRANZ, H. *Lebensschicksale Krimineller Zwillinge*. 1936.
- KRETSCHMER, E. *Physique and Character*. 2nd Edit. London 1925.
- LANDECKER, W. S. "Criminology in Germany." *Amer. Jour. Criminal Law and Criminology*. Jan.-Feb., 1941.
- LANGE, JOHANNES. *Crime as Destiny*. London 1924.
- LANGFELDT, GABRIEL. *Der dieb und der Einbrecher*. 1936.

- LAUVERGNE, *Les forçats*. 1844. (Quoted by De Quiros.)
- LOMBROSO, C. *Criminal Man*. 1895.
- LOMBROSO, C. *Crime: Its Causes and Remedies*. London 1911. (Introduction to English Edit. by Maurice Parmelee.)
- MACCURDY, H. L. "A Test for Measuring the Capacity of Secondary Schoolboys." N.Y.U. Ph.D. Thesis, Ch. 1. 1933.
- MAPOTHER, E.; and LEWIS, AUBREY. Art. "Psychol. Med." Price's *Text Book of Medicine*. 5th Edit. London 1937.
- MEZGER, E. "Die Bedeutung der biologischen Persoenlichkeitstypen fuer die Strafrechtspflege." *Mitteilungen der Kriminalbiologischen Gesellschaft*, Vol II. 1929.
- PINA, LUIS DE. "Delinquência, alienação mental e morplogia crani-ana." *Arch. da Repartição de Anthropologia Criminal. Psicologia Experimental e Identificacao Civil do Porto*, fasc. 3, 231-238. Dec. 1931.
- QUETELET. *Anthropometrie*. 1870.
- ROSANOFF, A. J.; HANDY, L. M.; and ROSANOFF, I. A. "Criminality and Delinquency in Twins." *Amer. Jour. Criminal Law and Criminology*. Jan.-Feb., 1934.
- ROSS, FRANK A. *Review Amer. Journ. Sociol.* 45, 477-480. 1939.
- SAUER, W. *Kriminalsociologie*. Berlin and Leipzig 1933.
- SCHNEIDER, F. E. E. "Physical Fitness of Recidivists assessed by Vital Capacity." *The Lancet*, 19.1.35.
- SLAWSON, T. *The Delinquent Boy*. Boston 1926.
- STUMPFL, F. *Die Urspruenge des Verbrechens, dargestellt am Lebenslauf von Zwillingen*. Leipzig. 1936.
- SUTHERLAND, E.H. *Principles of Criminology*. Philadelphia and New York 1939.
- TUCKER, WILLIAM B. "Physical Basis of Criminal Behaviour." *Amer. Journal Criminal Law and Criminology*, XXXI, No. 4. Nov.-Dec. 1940.
- WILLEMSE, W. A. *Constitution Types in Delinquency*. London 1932.

VIII

ALCOHOLISM AND CRIMINAL BEHAVIOUR

By DR. G. M. SCOTT

THE word Alcohol appears to have had its origin in the Arabic words Al-Kohl, meaning the fine powder of sulphide of antimony used for darkening the eyelids. It is rather difficult to understand how, in course of time, the word should become associated with the spirit produced in the process of fermentation of sugars or starches. It may be that the powder of sulphide of antimony had a peculiar fineness, and the words Al Kohl became synonymous with fineness or essence. Or it may be that the processes of manufacture of the powder by sublimation, and of intoxicating liquor by distillation were rather alike. However that may be, the word Alcohol, as it is popularly used to-day, refers to the important common constituent, Ethyl Alcohol, of the various alcoholic drinks, however much they may vary in taste, smell, flavour, or other property. There are very many intoxicating drinks, with different methods of preparation, and varying ingredients, but they are all made by fermentation of sugars or starches. They vary in name, and in alcoholic content, but their effects in general are the same. Many countries have their own particular form of alcoholic liquor. Scotland, for instance, has whisky; England, ale; Russia, vodka; France, brandy, and so on. As world communications have improved, however, and as people have tended to travel or emigrate more and more, so the various alcoholic drinks have become almost universal, instead of being mainly confined to the countries of their origin. In Britain the forms of alcoholic liquor in use are spirits such as whisky, brandy, rum and gin; wines such as champagne, claret, port, sherry, etc.; ale, beer and stout, cider and home made wines. In addition, and particularly among addicts, methylated spirit, surgical spirit and Eau de Cologne are common agents in the production of drunkenness.

Alcoholism means the condition produced by the action of alcohol on the human body. There are many degrees of the condition, and unfortunately from the point of view not only of description, but also of law, there are no definite names for the

varying degrees. Popular expressions such as "mildly intoxicated", "half drunk or half seas over", "mad drunk", "helplessly drunk", "dead drunk", etc., indicate only roughly the degree of intoxication which may be present, and they vary from place to place and from person to person. There is considerable confusion caused by the use of the words "drunk" or "intoxicated", to indicate conditions which may vary widely in degree. They may be and often are used for the condition in which there is little impairment of speech or balance or even of behaviour, as well as for that in which there is complete inability to walk or talk. There is a real need from both medical and legal points of view, for a more accurate description of different grades of intoxication, be they mild, moderate, severe, or total. It might have been hoped that the percentage of alcohol in the blood would lead to a dependable classification, but this has not been realised. There are too many variables in the individual factors of resistance to or tolerance of alcohol. Nevertheless increasing use is being made of estimations of the amount of alcohol in the blood in cases where the question of drunkenness arises, though to a greater extent in other countries than in Britain. It is possible to state that with a certain percentage of alcohol, *e.g.* .52 per cent. in the blood, the person must be helplessly drunk, but difficulty always arises in the case of lower percentages. In these cases the percentage estimation forms only a small and rather untrustworthy piece of evidence.

A Committee of the British Medical Association has defined intoxication in the following terms: "The word 'Drunk' should always be taken to mean that the person concerned was so much under the influence of alcohol that he had lost control of his faculties to such an extent as to render him unable to execute safely the task in which he was engaged at the material time." This definition, clumsy as its phrasing may be, may suffice in the case of motoring offences, but it is obviously unsatisfactory in the case of other offences.

ACTION OF ALCOHOL ON THE BODY

Alcohol, when taken internally, affects all the bodily systems. Its effect in the mouth is to irritate the mucous membrane, and this increases the secretion of saliva. If alcohol is taken undiluted, its action is to burn the mucous membrane, but alcoholic drinks are always diluted, so there is only an irritant action. In the

stomach a similar effect is produced with a resulting increase in the secretion of gastric juice, though the amount of pepsin secreted is not increased. The irritation of the mucous membranes of the mouth, gullet and stomach, reflexly stimulates the heart, and it is because of this that alcohol is so frequently used in cases of fainting. It is not the action of absorbed alcohol that accounts for it. Alcohol is absorbed from the stomach and small intestine, passes into the blood unchanged, and is oxidised by the tissues into carbonic acid and water. After it has been absorbed it causes a dilatation of the cutaneous blood vessels and a sensation of pleasant warmth is produced. This is one of the attractive results of taking alcohol. Contrast the expression "cold sober". Alcohol has a certain diuretic action, more pronounced perhaps in the case of gin than in that of other spirituous liquors. It has also an aphrodisiac action, partly as the result of its action on the genito-urinary tract, and partly from its operation on the nervous system. These are important in some cases of indecent behaviour and sexual offences.

By far the most important action of alcohol is that on the nervous system. While its effect on mucous membranes, because of its irritation, may be considered stimulating, on the nervous system it acts as a depressant and narcotic. Alcohol is, in fact, a narcotic poison, strictly comparable with chloroform and ether. It does not stimulate, it paralyses. The nervous centres are affected more or less in the reverse order of their evolution, the higher centres being affected first. Thus the cerebral cortex suffers earlier than the thalamus. The cortex receives impressions from the special sense organs, the eye, ear, nose, mouth and skin. It stores up these impressions so that they can be recalled later in the exercise of memory. It sends out impulses in response to impressions, and movements take place through the nervous control of muscles. The cortex is the seat of reason and judgment and self control, all of which are faculties of recent development in the evolution of man. In the course of this evolution the primitive instincts have become subordinated to selective judgment, and when sensory impressions are received by the cortex, discrimination takes place before muscular response is made. Generally speaking then, the higher centres control the lower or more primitive centres, and when this control is lessened or removed, the primitive instincts become more powerful or at least less restrained.

The first faculties to be depressed by the action of alcohol are

those of self-criticism and self-restraint. The sense of personal responsibility is blunted. Shyness and anxiety and fear are lessened. This results in an apparent intellectual stimulation. The person becomes more lively, his ideas flow more freely, and his conversation is less restrained, so that he may indulge in vulgarisms which would be repugnant to him under normal conditions. He laughs readily and immoderately. He sees the world through a rosy mist, and loses the caution which might prevent him from making mistakes. In most cases there is a general excitement which may give place later to argumentativeness or to outbursts of easily provoked rage. As the process of intoxication or narcotisation develops, judgment becomes more and more defective, self-control becomes less and less, incoherence of thought and speech appears, and finally there is unconsciousness which may deepen into coma. Accompanying this effect on intellectual activity, is the effect on the special senses and on muscular movements. Hearing, vision, taste and touch become impaired. There is a relative insensitivity to pain. Inco-ordination of muscular movements become evident, so that the person affected may find it difficult to take hold of his glass or to write his name. He finds difficulty in balancing and staggers when he walks, this being due, in part, to the action of alcohol on the cerebellum. Finally there comes the stage when all voluntary movements become impossible, so that the person lies helpless—this stage is frequently described as “paralytic”.

In certain individuals, the action of alcohol appears to be a little different. The period of vivacity either does not appear or is much shortened, and a state of depression becomes evident which develops into a kind of maudlin melancholy and this is followed by coma. It appears to depend on the nature of the person what effect alcohol will have upon him. There is more than a suggestion of truth in the adage “*In vino veritas*”, since alcohol, by paralysing self-control, helps to reveal the true nature of the individual. The common expression that in drunkenness “a man makes a beast of himself” epitomises the disastrous effects of alcohol on the highest qualities of mankind. Primitive instincts and impulses can be restrained or inhibited, and this power of inhibition, which is the highest function of the cerebral cortex, is the first to suffer in alcoholic narcotisation. Even in small doses alcohol blunts the higher activities of the brain and weakens inhibitions. It might be said that the effect is to impair the brakes so that the wheels run faster but without the safety that brakes help to ensure. For in-

hibitions such as self-restraint and self-criticism are the brakes which make for safety in social intercourse, and when these are impaired there is a risk of such speech or action as may bring the individual into conflict with the law.

It has been proved beyond doubt that alcohol impairs critical judgment, accuracy and concentration, but a person under the influence of alcohol may feel that his mental alertness is improved, his co-ordination better and his muscular capabilities increased. This is due to the blunting of self-criticism which occurs so early in the process of intoxication.

It must be emphasised again and yet again, that alcohol does not stimulate the nervous system but paralyses it.

It is easy to understand, therefore, why alcoholism should lead to criminal behaviour. Inhibitions, which are the latest acquisitions in our culture, are depressed, while the coarser, more primitive impulses of instinctive behaviour remain in action and tend to dominate conduct.

It is not possible to state with any accuracy which stages of intoxication, mild, moderate or advanced, are particularly associated with certain offences. This is partly because individuals vary so much in regard to the effect of alcohol upon them. It depends on the disposition, the physical condition, the intellectual powers and the previous training. It is also partly because offences may be committed at any stage of intoxication, except during the final stage of helplessness. It is, however, probable on theoretical grounds, and this is supported by practical experience, that, for instance, sexual offences are more likely to be committed during the early stages of drunkenness, because in later stages desire declines and performance may become impossible. At these early stages too, there is committed a considerable proportion of the thefts, by housebreaking or otherwise, which may be attributable to the action of alcohol. The weakening of moral feeling and the blunting of the fear of consequences combine to produce a state of mind in which such offences become more likely.

In the moderate stages of intoxication there is frequently seen an almost complete loss of self-control, and it is then that outbursts of passionate rage are common, often without any adequate provocation. These outbursts may lead to serious assaults, with or without weapons. There is a complete disregard of consequences, and the most severe injuries may be inflicted or sustained. It has to be remembered that along with the paralysis of self-restraint,

there is a blunting of ordinary sensation, and fights tend in consequence to be more violent and more prolonged. Suicidal attempts too are perhaps more common at this stage than at any other, though the depressed stage which follows an alcoholic debauch also yields a considerable number of the attempts which can be attributed to the action of alcohol.

In the advanced and last stages of drunkenness, there occurs that very large section of offences described as "drunk and incapable" or "drunk and disorderly". In many of these cases the person lies in the street unconscious, and his helplessness leads frequently to the commission of crimes on the part of others. Thefts are particularly numerous, and the victim is left without a penny in his pockets. It is by no means uncommon for violence to be added if the victim, under rough handling, begins any form of resistance. It is often difficult to discover whether the injuries which some of these cases present, are due to falls or to violence inflicted by others. As a rule no recollection of such injuries is preserved, and the person may be attended to, and may have his cuts stitched without becoming aware of it.

ACUTE ALCOHOLISM

Intoxication, as so far described, with its phases of animation, excitement, inco-ordination and coma, is best referred to as Acute Alcoholism. It represents the common picture of an isolated act of excessive drinking. It may and does occur in individuals with a stable nervous system, but it is more apt to occur in those who are mentally unstable. People who have suffered from head injury or brain disease or from heatstroke, the epileptics and the mentally defective and most of the insane, all tend to succumb more readily to the action of alcohol. Such persons tend to have diminished self-control owing to inherent weakness of the brain, and it is to be expected that not only should less alcohol be required to produce in them the state of acute alcoholism, but also that the varying phases should be more pronounced. There is, on the whole, a greater tendency to violence under the influence of alcohol among these sufferers. It should be stated here that, so far as my experience goes, the mentally defective do not commonly indulge in alcohol to excess. This may be partly due to the lack of means to purchase liquor and partly to the fact that they are in many ways free from the stresses of life which normal persons have to with-

stand and for which alcohol provides a temporary means of relief or escape.

CHRONIC ALCOHOLISM

Acute alcoholism may be a rare event in the lives of individuals who habitually drink alcoholic liquors, but in many cases there are frequent repetitions. It is not altogether uncommon to meet persons who get intoxicated almost every day, and it is astonishing to note how long this process may continue without any great damage to mind or muscle or other organs becoming apparent. It depends on the type of person, and on his other ways of life, how long he can continue to drink to excess without disaster. The constant indulgence in alcohol to excess even without complete intoxication leads in time to deterioration in efficiency of mind and body and to a lowering of moral standards. The individual becomes inefficient at his work; he becomes lazy and untruthful, often irritable and quarrelsome, and his conduct in his home becomes impossible to tolerate. He becomes suspicious, and this, combined with diminished self-control, leads to assaults on the members of his family.

This chronic alcoholism is most often encountered in persons of mental calibre below the average, though not in mental defectives, except rarely. It is commoner among unskilled labourers than in any other section of the community. It is responsible for a great deal of the poverty and misery that exist in so many homes, and directly and indirectly it is the prime cause of many of the crimes and offences which are dealt with in the courts.

ALCOHOLIC INSANITY

Alcoholism can lead to several forms of insanity, the chief of which are Delirium Tremens, Korsakow's Psychosis and Alcoholic Dementia. Some authorities have considered that the characteristic features of acute alcoholism justify its consideration as a transient form of acute insanity. Maudsley, for instance, has said "Alcohol yields the simplest instance in illustration of the disturbing action on mind of a foreign matter introduced into the blood from without: here, where each phase of an artificially produced insanity is passed through successively in a brief space of time, we have the abstract and brief chronicle of the history of insanity. . . . The different phases of mental disorder are compressed into a

short period of time because the action of the poison is quick and transitory." This is, however, a view which has not been accepted in practice.

DELIRIUM TREMENS

This usually occurs after a prolonged period of excessive drinking, more particularly if little or no food has been taken. It may occur in a heavy drinker if he becomes the subject of illness or injury, and it is not uncommon for it to appear in a habitual drinker whose supply of alcohol has been suddenly cut off as, for instance, by his admission to Prison.

The characteristic symptoms are excitement, sleeplessness, and frightening hallucinations. The sufferer imagines that he sees creatures such as snakes or rats crawling over him or over the walls or floor of his room. Or he may see figures which threaten him with weapons, or he may imagine that he has been condemned to death. There is usually a state of extreme terror, and assaults on persons entering the room are not infrequent. There may also be attempts at suicide, but these are, as a rule, ineffective. Generally, there is complete amnesia for these happenings after recovery, but at times there appears to be a hazy recollection of them.

The attack lasts, as a rule, for a few days only, a sound sleep being the prelude to recovery. Occasionally, however, it is prolonged, becoming gradually less violent in character. It is occasionally followed by noticeable mental deterioration.

KORSAKOW'S PSYCHOSIS

This is a rare form of insanity caused by long continual indulgence in alcohol. It is characterised by disorientation, hallucinations and loss of memory, and it is accompanied by polyneuritis. I have seen very few cases of this type of alcoholic insanity, and the offences which have led to their reception into Prison, have always been breaches of the peace or drunkenness.

ALCOHOLIC DEMENTIA

This develops in a certain number of individuals who habitually drink to excess. There is progressive deterioration of mind and body. Memory becomes greatly impaired, moral sense is lost and

self-control is greatly diminished. The person becomes heedless of his appearance, his work and his responsibilities. Delusions and morbid suspicions are common. He imagines that he never gets a square deal, that his wife is unfaithful to him and that his family plot against him. He is dismissed from his work, and imagines that this is the result of spite on the part of the management or his fellow workmen. A fairly common happening in such cases is a series of assaults on his wife or more rarely on his children. Or there may be indecent behaviour and sexual offences, usually against young children.

It must be noted, however, that there are other factors in addition to the long continued abuse of alcohol, which assist in the production of symptoms. The individual is usually at or beyond middle age. His arteries are thickening and hardening, and this applies more particularly to the arteries of the brain. He tends to suffer from dizziness and may have seizures of an epileptiform type.

It is difficult to say just how many cases of insanity are caused by alcohol and alcohol alone. Alcoholism is often associated with mental disorder, and may be the precipitating cause of an attack, but the real origin is elsewhere. In 1,000 cases of mental disorder, I have found associated alcoholism in rather more than 100. Among these were 12 cases of Delirium Tremens. Of the others, only a minority could be considered as due to alcohol alone, not more than 30. So that my experience has been that only about 4 per cent. of my cases of insanity have been due to alcoholism. The figure seems small in comparison with the usual figures of other observers, whose average is in the neighbourhood of 10 per cent. or higher.

AMNESIA AND ALCOHOLISM

It is frequently alleged by offenders that as the result of having too much drink they have forgotten the events which led up to their arrest. It is perhaps natural that they should try to lay the blame for their offences on drink, and the common expression is—"I was drunk at the time", with the addition expressed or implied "and I remember nothing about it". This is an excuse that demands careful scrutiny. It is clear that persons who are helplessly drunk or comatose cannot remember happenings during this stage of their intoxication. It is, however, practically impossible for any active crime to be committed in this state, and the passive

offences are confined to "drunk and incapable". In the early stages of intoxication, however, where there is diminished self-criticism and some loss of self-control, while there is a slight blunting of memory and a corresponding slight vagueness of recollection, there is no real amnesia, and careful questioning will, as a rule, elicit all necessary facts.

It is in the later stages of intoxication that uncertainty arises. In these, there is practically complete loss of self-criticism and a very considerable loss of self-control. There is inco-ordination of ideas as well as of muscular movements. In these circumstances, it is not to be expected that recollection of incidents will be clear or correctly timed or placed. There is marked blurring of details. At the same time it is interesting and suggestive to find that injuries sustained by a person in the moderate or severe degrees of intoxication are often remembered with a surprising clarity, whereas there is often professed amnesia for assaults or injuries which the person has himself committed. In the majority of instances, I incline to think that the amnesia is rather like hysterical amnesia—there is a certain vagueness of recollection which can be easily wished into complete forgetfulness. I have been impressed by the frequency of the improvement in recollection after conviction, and I hesitate now to place much credence in the statement "I was drunk and I do not remember". There certainly are cases in which I have been convinced that amnesia has existed and has continued, but I think that such cases occur more rarely than is commonly supposed.

One finds that in the case of sexual offences particularly, the excuse of drunkenness and consequent forgetfulness is frequently put forward, while in the case of thefts of various kinds, the admission is made of indulgence in alcohol but forgetfulness is not alleged. This is presumably because in the latter type of case the public disgrace is considered less, and the probable consequences are less severe.

ALCOHOLISM AND CRIME

Lord Alverstone has said that "Ninety per cent. of the crime of this country depends upon intemperance", and there are others who have agreed with this estimate. I should prefer to put it rather that 90 per cent. of the crime of this country is associated with alcoholism, but I consider that in any case the estimate is too high. Many, probably a considerable majority, of the crimes com-

mitted by youths between the ages of 16 and 20, are not associated with alcoholism, and the same applies to crimes committed by the old. It is not easy to assess with any accuracy the extent to which alcohol is responsible for crime. Admittedly it predisposes to crime especially in those who are already predisposed by inheritance or faulty training or vicious environment, but it is certainly not the case that if there were no alcohol, 90 per cent. of the crime of this country would cease. The causes of crime lie much deeper than the excitation of alcohol.

The cases of "drunk and incapable", or "drunk and disorderly", form about 30 per cent. of all offences. This figure varies slightly from year to year and from decade to decade. Apart from these cases, it is certain that alcohol is responsible for numerous cases of assault. From my own observation I should put the figure at nearly 70 per cent., but again I must emphasise that a majority of these assaults are committed by persons who are inherently deficient in self-control, and that there is an ever present possibility of assaults on their part even without the factor of alcohol. In the case of "breaches of the peace", the figure is probably rather higher, but is less than 80 per cent. On the other hand, where thefts are concerned, the figure is considerably lower. I estimate this figure at something like 40 per cent., and a similar figure would represent the proportion of sexual offences attributable to the action of alcohol. These figures do not, and cannot pretend to be accurate. They depend to a considerable extent on the statements of offenders, and these are by no means reliable.

Even with these rough figures, however, it is possible to say that alcoholism is associated with something like 70 per cent. of all offences. One can only guess as to its actual responsibility for crime, but there can be little doubt that it transcends all other factors in the causation of crime, just as it does in the production of poverty, unhappiness and wretchedness.

DRUNKENNESS AND THE LAW

Mere private intoxication is not an offence at common law, but drunkenness in public is an offence when it amounts to a breach of the peace or a contravention of public order. Until the nineteenth century, drunkenness was not considered to excuse criminal action. Gradually, however, it was recognised that alcohol impaired or destroyed self-control, and that when under the in-

fluence of alcohol, a person is not fully responsible for his actions. This cannot be questioned since the action of alcohol on the nervous system is to undermine or paralyse those inhibitions which are the chief guard against anti-social acts. Even though the drunkenness results from a voluntary act, this does not affect the action of the drug, and from that point of view it appears eminently reasonable that drunkenness should be put forward and regarded as an extenuating circumstance. At any rate, present legal opinion appears to be, that while drunkenness does not reduce culpability, it may mitigate the punishment. The general position may be stated as follows: "Insanity, whether produced by drunkenness or otherwise, is a defence to the crime charged. Evidence of drunkenness to such an extent as to render the accused incapable of forming the specific intent essential to constitute the crime, should be taken into consideration with the other facts proved in order to determine whether or not he had this intent. Evidence of drunkenness falling short of this inability to form the specific intent, and merely establishing the fact that his mind was affected by drink so that he more readily gave way to violent passion, does not rebut the presumption that a man intends the natural consequences of his act." It is obvious, then, how important and indeed necessary it is that the degree of drunkenness should be determined as accurately as possible in the case of any offence. In connection with this, there are other considerations to take into account, *e.g.* the character and disposition of the person concerned, his previous history, and his usual reaction to alcohol.

While it is true that in the majority of cases, drunkenness has become an extenuating factor, this does not hold for certain offences, and in particular, motoring offences, in which drunkenness aggravates the offence. This is, of course, eminently reasonable, but at the same time it could equally well be argued that a person who, by his own voluntary act, renders himself more liable to commit a crime, should be considered to have increased the gravity of his offence. Punishment in accordance with this view would be more salutary than it is at present. It must seem unfortunate to anyone that the plea of drunkenness should be confidently relied upon to mitigate punishment. One cannot help feeling that, from the point of view of the interests of the community, it would be a wiser plan either to disregard the plea of drunkenness in relation to a crime or to consider it an aggravation. The natural aim of law is as much the prevention of crime as its punish-

ment, and this aim cannot be achieved by an indulgent view in drunkenness. It must always be remembered, however, that in many cases alcoholism is not the sole condition that has to be taken into account in assessing responsibility. Alcoholism is a frequent concomitant of mental instability and mental disorder. It has been held by some that alcoholism is really the result of a disordered mind. This is an overstatement of a partial truth for it is undeniable that the persistent abuse of alcohol can of itself, in normal and stable persons, cause a deterioration of mind and character. As Dr. Norwood East says, "Inebriety is not a disease. It can be induced by cultivation, and the desire for drink can be increased by indulgence."

Alcoholism and Crime are both social problems, which have perturbed and perplexed the minds of men for centuries. They are to a considerable extent interdependent, and it can be asserted that reduction in alcoholism is certainly followed by a reduction in crime. Many remedies have been proposed to achieve this reduction; many are even now being tried and practised, but much remains to be done. For instance, any increase in the price of alcoholic liquors, any reduction in the number of public houses or licensed shops, any curtailment of the hours during which liquor may be sold, can be expected to bring about a certain reduction in alcoholism. Improvements in housing, in working conditions, in forms of recreation, and above all, improvement in and extension of education, combine to counteract the attraction of the public house, and the lure of alcohol. On the other hand, the growing complexity of modern life, the loss of craftsman's pride, the increasing pace of living and the sense of frustration in an increasing number of individuals who cannot keep pace with their fellows, tend to encourage the resort to alcohol as a means of escape.

The Inebriates Act of 1898 attempted to deal with the habitual drinker, where drunkenness brought him into conflict with the law. It speedily became a dead letter, however, and there have been no committals under this Act for many years. This Act did not pretend to deal with the causes, but only with the results of chronic alcoholism. Even so, it does seem as if there were room for such an Act, faithfully carried out. It is futile to keep sentencing offenders to short periods of imprisonment year after year, and it is pitiable to see the gradual deterioration of individuals who, but for alcohol, might be decent citizens. It is only in Prison that they

have any chance of rehabilitation, mental, moral and physical, but the periods of imprisonment are too short to be effective in reducing or extinguishing the craving for drink. Prolonged sentences might be valuable because of the enforced abstinence, but it is undesirable on other grounds that such cases should be treated in Prison. Inebriates require to be saved from themselves and from their associates, and they might, in certain cases, derive benefit from the modern methods of psychotherapy, which could be applied in special hospitals for Inebriates.

It is an Utopian dream to imagine that complete prohibition of alcoholic drink is at present a possibility. The recent experience of the United States of America is evidence that there is no country which is sufficiently prepared for such a step. Similarly, the complete abolition of crime due to the action of alcohol cannot as yet be envisaged. Many attempts have been and are being made, with a certain degree of success, to reduce the incidence of alcoholism, but the problem persists, and it seems certain that other measures will be necessary before there can be further appreciable reduction. Whatever the means—and about this there may be many opinions—the aim to strive after is a reduction in the number of cases of drunkenness. We may confidently expect that this would lead to a greater reduction in the number of offences before the courts than any other single measure which we can at present imagine. The dictum "*Causa ablata, morbus tollitur*", is as true in this connection as it is in the problems of medicine. Here we know the cause. The remedy lies in our own hands.

IX

SEXUAL OFFENDERS

By DR. W. NORWOOD EAST

I. DISCUSSION

ONE of the purposes of the criminal law is to maintain the standards of behaviour which are considered to be necessary for the welfare of the community, but which cannot be enforced by the operations of the civil courts. This is particularly noticeable in the case of sexual offences, but the law does not inflict penalties upon all the acts which the ecclesiastical law prohibits and formerly punished. The criminal law is concerned with the grosser breaches of sexual misconduct which, on account of their abnormal character, associated violence, or other circumstance, or the immaturity or mental disability of the victim, can only be repressed by criminal sanctions.

The eminent English jurist Jeremy Bentham (1748-1832) in his classification of offences referred to "imaginary offences" which he defined as "acts which produce no real evil, but which prejudice, mistake or the ascetic principle have caused to be regarded as offences. They vary with time and place. They originate and end, they rise and they decay with the false opinions which serve as their foundation." He instanced the vestal virgins who were buried alive for unchastity and he considered, so far as the public are concerned, that sexual offences in which there is neither violence, fraud, or interference with the rights of others could be arranged under the head of "imaginary offences".

Sexual offences are more liable to be misjudged by prejudice and ignorance than most other forms of criminal behaviour, and bias is almost inevitable if conduct is reviewed solely in the light of narrow personal experience and the tastes and distastes of the assessor. Many persons of both sexes are grossly ignorant on sexual matters in spite of the modern tendency to discuss the subject with a considerable degree of freedom. Some husbands, in effect, repeatedly commit rape upon their wives because they do not understand the art of married life, and do not realise that a woman is at a disadvantage unless a psychical approach precedes each physical

contact; sexually anaesthetic men and women, who are incompetent to pass judgment upon the inter-relationship of the sexes, may be called upon to assess the guilt of a sexual offender; and sexual behaviour is often assessed by persons who regard any sexual activity as perverse unless it conforms to their accustomed and restricted pattern of behaviour.

Sexual activity is essentially a physical response to a mental stimulus which may affect different persons in different ways, and one person may be attracted by a feature or quality to which his neighbour is indifferent. Most discussions on crime take place on common ground, and the disputants address the facts from similar experiences of life. In sexual offences, however, this is seldom possible, and no one can be sure that he approaches the problem from the same angle as his fellows whose sexual experiences, and the direction of whose innermost thoughts on such matters, are usually undeclared.

This is particularly the case where women are concerned. A man may have some reason to believe that his manner of approach to sexual conduct or misconduct corresponds to that of other men, but few may learn the innermost thoughts of women on the subject. The matters which are most significant to them in connection with sex are usually concealed and unsuspected by others.

Further, although we may generally pass sound judgments upon the ordinary affairs and manner of life of our friends and acquaintances, a few of whom may for a moment unlock the cupboard which contains a skeleton and expose it to our view, fewer still, in affairs of sex, open to others the double-locked sanctuary which retains the highest and noblest memories of a deep affection; for these are often too sacred to be lightly uncovered even to oneself. They may, perchance, be secretly taken from their wrappings in hours of difficulty or despair to serve as an inspiration or as an encouragement, but they rarely reach the light of day save in the delirium of illness or in the low mutterings of impending death.

The importance of viewing sexual offences broadly is obvious when one considers the evil of prostitution, for it is tolerated in some countries and not in others. Moreover, as Jeremy Bentham pointed out, the kept mistress may be regarded as almost as infamous as the prostitute. When, however, the former remains continuously under the same protection she may compare favourably with the woman who indulges in one or several marriages for a limited period. Here, as so often elsewhere, it is more instructive

and equitable to ascertain the purpose of behaviour than to consider the manner of its presentation.

It is not intended to belittle the gravity of sexual crime. Indeed, the Pentateuch code of social hygiene forbade homosexuality and bestiality, incest and other sexual irregularities. But, in order to attain a true perspective of this complex group of offenders, it is necessary to recognise the fact that sexual crime may be the result of depraved brutality, selfish indulgence or sublime emotion. Moreover, Von Hentig has reminded us that in sexual offences the element of seduction emanates from many victims who proceed to the higher rank of accomplices.

Sir James Fitzjames Stephen in his Digest of Criminal Law placed sexual crimes under the heading of offences against morality, and Thoinot and Weyssé entitled their well-known book on the subject *Medico-Legal Moral Offences*. If the term moral is used for matters which are concerned with character and disposition, and with the distinction between right and wrong, it seems to have no special application to sexual crime. If it suggests the religious principle involved in the misconduct it may confuse the issue in a medico-legal discussion.

On the other hand, criminals may be encouraged by a recent medical declaration which alleges that on no account should the sexual instinct be thwarted, and that continence is definitely harmful. To this a critic justly replies: "Presumably a state of cultural stagnation is well worth while if pre-marital promiscuity and complete sexual licence are the recompence." Indeed, if so, why should not the aggressive and acquisitive criminal also be allowed to exercise his instincts as he wills, and hasten the social chaos which must inevitably follow on unrestrained licentiousness?

When we consider the state of flux which exists to-day concerning sex morality, and the fact that we cannot yet see clearly its future direction, it is, surely, both elementary and fundamental steadfastly to insist that the matter be connected with morality in general?

Many persons will be in general agreement with Cardinal Newman when he wrote: "A medical philosopher, who has so simply fixed his intellect on his own science as to have forgotten the existence of any other . . . will think himself free to give advice and to insist upon rules, which are quite insufferable to any religious mind and simply antagonistic to faith and morals. It is not, I repeat, that he says what is untrue supposing that man were an

animal and nothing else: but he thinks that whatever is true in his own science is at once lawful in practice—as if there were not a number of rival sciences in the great circle of philosophy, as if there were not a number of conflicting views and objects in human nature to be taken into account and reconciled, or as if it were his duty to forget all but his own. . . .”

It has seemed necessary to make this digression, for the efforts of those who spend their lives in an attempt to advance the scientific approach to criminal problems are made still more difficult by ill-informed statements which antagonise the majority of lawyers, administrators, doctors and laymen. A change of view is often essential for progress, but it must be founded upon well-established truth and must also be accurately timed. A wise American psychiatrist, Harold S. Hulbert, has recently stated: “Medicine, psychiatry, may properly be used to help the law but in its adolescence must not displace the law nor arrogate unreviewable infallibility to itself. In our culture the law is still, and we think properly, the last word in dealing with human conduct and misconduct. It is the last word but need not be the sole word.”

2. STATISTICAL FINDINGS

Sexual offences are classified officially as follows:

Unnatural offences; *i.e.* carnal knowledge of any animal and carnal knowledge by a man of a man or woman per anum. Any person above the age of fourteen years who permits himself or herself to be so carnally known is a principal in the first degree.

Attempts to commit unnatural offences; including assaults with intent to commit unnatural offences, indecent assaults upon male persons, and male persons soliciting for immoral purposes. Indecency with males.

Rape; that is, the offence of having carnal knowledge of a woman against her will by force, fear or fraud.

Carnal knowledge of a female idiot, imbecile, defective or lunatic.

Indecent assaults on females.

Defilement of girls under 13 and of girls aged 13 and under 16 years.

Incest.

Procuration; including living on the earnings of a prostitute, detaining women in brothels, etc.

Abduction.

Bigamy.

Prostitution.

Indecent exposure.

From the medical point of view, however, some cases of murder, attempted murder, wounding, assault, attempted suicide, burglary, theft, being on enclosed premises and arson are essentially sexual offences.

The number of official sexual offences known to the Police in England and Wales in the year 1938, the last for which figures are available at the time of writing, was 5,018, against 4,646 in 1937. The number of crimes known to the police, however, exceed the number of persons found guilty because many crimes are committed of which the offenders remain undiscovered or, though discovered or strongly suspected, cannot for some reason be prosecuted; and also because a person convicted of an offence frequently admits numerous other offences and asks that they may be taken into account when the court passes sentence. In such a case, though there is only one person convicted the conviction covers many crimes.

Of the 2,321 persons found guilty of indictable sexual offences during the year 1938:

119 or 5 per cent. were under the age of fourteen.

356 or 15 per cent, were aged fourteen and under seventeen.

354 or 15 per cent. were aged seventeen and under twenty-one.

209 or 9 per cent. were aged twenty-one and under twenty-five.

296 or 12 per cent. were aged twenty-five and under thirty.

1,014 or 44 per cent. were aged thirty and over.

Among these were 1,104 cases of indecent assault and 274 of bigamy.

The number of sexual offenders dealt with at Assizes, the Central Criminal Court, and Quarter Sessions was:

18 aged fourteen and under seventeen.

150 aged seventeen and under twenty-one.

287 aged twenty-one and under thirty.

527 aged thirty and over. A total of 982.

The reconviction rates among males guilty of five types of offence were:

Age	Violence against the Person	Sexual Offences	Frauds and False Pretences	Breaking and Entering	Larceny
16 and 17	21·4	22·9	48·0	35·1	28·8
18-20	28·6	11·3	30·5	28·5	26·3
21-29	19·6	16·6	24·4	28·0	23·1
30-39	10·5	13·1	15·8	30·7	14·9
40 and over	8·3	5·6	9·9	32·1	10·0

The number of persons found guilty of indictable sexual offences since the year 1934 divided into age-groups was:

Year	Under 17	17 and under 21	21 and under 30	30 and over	Total
1934	353	232	400	829	1,814
1935	347	235	379	811	1,772
1936	429	232	429	838	1,928
1937	397	294	394	950	2,035
1938	475	354	478	1,014	2,321

The following figures show the proportion per 100,000 of the population of persons aged 17 and over who were found guilty of violence, sexual offences, frauds and false pretences, breaking and entering, larceny and all other offences during the years 1934-1938:

Year	Violence against the Person	Sexual Offences	Fraud and False Pretences	Breaking and Entering	Larceny	All other Offences
1934	3·9	4·9	15·6	10·8	110·2	5·8
1935	4·4	4·7	15·0	10·1	107·7	5·6
1936	4·3	5·0	14·9	10·0	111·3	5·7
1937	4·9	5·3	14·1	11·2	116·5	5·8
1938	4·7	5·9	15·3	13·1	117·3	6·2

There was a slight decrease in the proportion of persons found guilty of frauds and false pretences; a slight increase in the proportion of persons found guilty of violence against the person,

sexual offences and in the "all other offences" group; and a still larger increase amongst offenders found guilty of breaking and entering and larceny.

The proportion of sexual offenders is not sufficient to cause alarm, and the sentences imposed for this, as for other groups of offences, are much less severe than they often were in the early years of the present century. If imprisonment is regarded as a means of ensuring social order there can be no doubt that a further measure of security can be assured by the imposition of the authorised heavier penalties.

The number and sexes of persons convicted during the year 1938 of sexual offences at Assizes and Quarter Sessions are as follows:

Offence	Persons convicted	
	Males	Females
Unnatural offences	58	—
Attempts to commit unnatural offences ..	76	1
Indecency with males	141	—
Rape	40	—
Indecent assaults on females	115	—
Defilement of girls under 13	31	—
Defilement of girls 13 and under 16 ..	179	—
Incest	40	4
Procuration	15	2
Abduction	4	—
Bigamy	195	81

In addition to the above, persons aged 17 years and over (sexes not differentiated) were found guilty by courts of summary jurisdiction as follows: Attempts to commit unnatural offences (indecent assaults on male persons under 16), 225; indecent assaults on females under 16, 657; indecent exposure, 1,574; offences by prostitutes, 3,192.

The Annual Report of The Prison Commissioners for 1938 shows that 246 males were received into prison for unnatural offences and attempts, etc.; 483 males and one female were received for rape and other offences against females; 110 males and 22 females for bigamy; 154 males and 32 females for brothel keeping and living on the earnings of prostitutes; 5 men and 172 women for prostitution; and 449 men and 81 women for indecent exposure.

3. PSYCHOLOGICAL FACTORS

Many sexual offences appear to be trivial in character, but occasionally the effect upon the victims may be profound, and cases arise in which an accidental and non-criminal sexual experience in childhood produces lasting effects. The mental disturbance which may follow a sexual assault may far exceed any physical injury sustained. On the other hand, sexual offences sometimes appear to do little permanent injury to the person assaulted.

The composite character of the sex instinct is generally recognised, and many sexual offences are related to the imperfect and irregular development of the components due to pathological heredity and accidental associations forming new sexual aims. When circumstances prevent the release of sexual energy along the normal channels a diversion may take place through an infantile outlet in predisposed individuals. Moreover, as Putnam observed: "It is true, however those who have not looked into the matter may think otherwise, that, in the eye of science, perverted instincts such, for example, as an excessive passion for a person of the same sex carried from the realm of thought into act, finds its analogue in many overdone or even quasi-normal relationships of daily life. It is a question of degree that is at stake, and although for purposes of punishment, prevention, public self-protection and social standards we must draw sharp lines, yet knowledge should make us prudent in passing scientific judgments."

The same writer, discussing the so-called "insufficiently dressed dreams", writes: "Such dreams show what we ought in the interests of human sympathy to recognise that between ourselves and those whom we stigmatise as exhibitionists, and therefore criminals, the difference important as it is, is one of degree alone."

I have stated elsewhere that the recognition of the fact that an act is culpable appears to depend largely upon the manner in which we react to illegal conduct, whether with fear, disquiet or complacency. The probability that in certain circumstances we may succumb to temptation ourselves and commit similar offences will affect also our estimates of turpitude and blameworthiness and, as Jeremy Bentham pointed out more than a hundred years ago, an offence which is premeditated will be generally more alarming than one in which design and intention can be excluded.

It should be added that many sexual crimes are unpremeditated.

The view that sexual crime is usually an expression of mental abnormality is common, but often incorrect. The strength of the sexual instinct varies in different persons. This is generally recognised, and it appears to be largely dependent upon physiological and psychological factors which the individual is unable to determine or influence. The force of the instinct is sometimes sufficiently strong to cause the person to commit a sexual offence regardless of the penalty. In other persons there may be no urge to carry out any sexual activity whatever. Normally, sexual activity should be expressed through biological channels, and the various preliminaries related thereto; abnormally, action may go no further than the preliminary activity, or it may be expressed in directions which are not biological.

It is convenient to regard the earliest form of sexual activity as autoerotic, that is to say, the individual discovers that he can obtain sexual pleasure from self-stimulation.¹ This may start in infancy or early childhood, and is probably at first a purely mechanical activity. Through propinquity or more specific environmental stimulus, phantasies will develop around this form of pleasure in association with persons of the same or opposite sex or, in some cases, other animate or inanimate objects. For many years the normal sexual goal may not be known or understood, therefore, there will be a tendency for these phantasies to concern themselves with all possible relations and emotions that may arise between human beings. Hence, in phantasy, sexual feeling may become associated with the infliction and bearing of cruelty or may interest itself in activities such as excretion, exhibitionism and the like. Their exact form will depend upon the experience of the individual—his treatment by adults, chance experience, or books and stories that he reads. At the same time, various forces will oppose both a free sexual development of the child and sexual development along abnormal lines. First, there will be the general disapproval and condemnation of overt sexual behaviour; second, the general pressure applied to make the individual conform in development and behaviour with what is considered right and necessary in the social system. The first type of opposition will tend to drive out of the forefront of the mind, or its available consciousness, all sexual preoccupations and interests, particularly those of

¹ I have made full use in much that follows of the views put forward by W. H. de B. Hubert and myself in our recent "Report on The Psychological Treatment of Crime".

the less acceptable kind. Exactly how this is achieved will depend upon the constitutional type. In the hysteric there will be, for example, a dramatic severance between the "conscious" and "unconscious", sexual feeling being delegated to the latter. The obsessional will elaborate highly complicated systems of protective devices. The average person will, in early years, tend to keep sexual material from attention by associating it with an unpleasant feeling tone, and parallel to this, will develop "harmless" interests and activities which allow some kind of partial fulfilment of his wishes by means of various common factors between the crude and the sublimated activity. The second type of obstructive factor will continuously tend to shape the individual into leading, or preparing to lead, a monogamous heterosexual life, highly complicated in form and which consequently may often become associated with other sexual patterns less socially acceptable.

In dealing with sexual abnormality it is important to realise that our social system, however desirable it may be, is but one of many alternatives. For example, the highly civilised Grecian States showed at different times other sexual patterns. Homosexuality, for instance, being encouraged to strengthen educative influences for cultural purposes, or to make more cohesive, self-sufficient, and all-embracing a special military system. Even in our own civilisation, the specific forces directed to the attainment of the most acceptable form of sexual activity are not entirely efficient in attaining this end and these deficiencies are, at times, directly related to the formation of sexual abnormality.

It is convenient to regard a true sexual perversion as sexual activity in which complete satisfaction is sought and obtained without the necessity of heterosexual intercourse. It must be persistently indulged in, preferably in reality, at any rate in phantasy, and must not be merely a substitute for a preferred heterosexual activity which, for some environmental reason, is difficult to obtain. Ordinary forms of autoeroticism are excluded and also perverse activity which is preliminary to ordinary sexual relations or is designed to achieve it.

Sexual perversion may mean an interest in an abnormal sexual object, in an abnormal sexual activity, in a combination of the two, or in a synthesis of the two. Examples are provided by a case of bestiality, an exhibitionist, a sadistic homosexual, and a type of

transvestite (*i.e.* one in whom sexual pleasure is associated with wearing garments of the opposite sex).

Investigation of a large number of perverts shows that a true perversion may be regarded as fundamentally a simple tendency. A "pure" perversion is uncommon; here, usually, in addition to the main activity there is interest in and frequently a performance of other perversions, and it may be difficult in cases of multiple perversions to know under which heading the particular offender should be classified. Frequently the sexual activity shows itself in the performance of more than one perversion. I have recorded a case in which exhibitionism, masochism, flagellation, frottage and bestiality were combined in the same man, and the combination of homosexuality with sadism or masochism is extremely common. There seems to be in some persons, therefore, a tendency towards general sexual perversion and that other factors determine which shall be the source of particular interest. It would appear that in cases of this nature one is dealing with a personality factor since environmental factors alone would be unlikely to produce such diverse behaviours. Further, many sexual perverts are quite normal in ordinary heterosexual relations but have a strong bias towards one and sometimes prefer, more than one sexual perversion; moreover, cases of sexual perversion often occur in families of sexual perverts under circumstances in which common environmental factors are extremely unlikely.

The environmental factor associated with sexual perversion may be an early experience of perverse activity before ordinary heterosexual activity has occurred, or been clearly comprehended. It may arise from a very early natural experience and its emotional recoil, or from a more recent happening which actively repels normal heterosexual life. In some cases a more general environmental factor may favour the development of the perversion in suitably disposed persons.

4. PSYCHIATRIC FACTORS

Sexual offences are occasionally directly attributable to mental defectiveness, mental disease, psychoneurosis and certain types of psychopathic personality, and the culpability of the accused may require special consideration at his trial. It is unnecessary to consider here the various legal and medical problems which may arise in relation to criminal responsibility in sexual offences since,

generally, the principles involved are applicable to other forms of criminal behaviour.

Sexual offences come second in frequency among mentally defective persons received into prison, offences connected with the acquisitive instinct—theft, fraud, embezzlement and false pretences—taking priority. The sexual crime may be homicidal, but in defectives it is usually minor in character. Occasionally two defectives are associated in the same sexual offence. The importance of criminal sexual behaviour in mentally defective persons rests more in the fact that it will almost certainly be repeated, unless the defective is detained in a custodial institution, than in the serious character of the behaviour.

Schizophrenia is rather frequently associated with sexual offences of various kinds, and with murder and attempts at murder which are essentially sexual in character. Morbid impulsive sexual conduct may be an early manifestation of the disease and the phantasies, delusions and hallucinations which may be present are often frankly sexual in character and may relate to the opposite sex—heterosexual, or the same sex—homosexual. The offender often has insight into his condition and is willing to discuss the events connected with the crime.

Manic-depressive disease may be associated with sexual crime in either the elated or depressed phase. In the elated phase the sexual crime is generally impulsive. In mental depression homicidal attacks are not infrequent and murder may be committed as the result of sexual delusions. It is in this type of case, and in examples of involutional melancholia, that the sexual murder is so often carried out from the highest motive and is entirely altruistic in purpose. On the other hand, in mild conditions of mental depression a sexual crime may be essentially egotistical and due to the fact that the offender endeavours to allay his depression by temporarily arousing a pleasurable experience.

General paralysis of the insane was at one time alleged to be more frequently associated with sexual crime than any other form of criminal behaviour. This is not so. The most frequent crime to be associated with this disease is theft, and when sexual offences result they are not usually of the major sort.

The alcoholic insanities are rather frequently associated with sexual crime; and the well-known aphrodisiac action of alcohol, together with the blunting of conscience and reason which accompany intoxication, often result in serious and minor forms of

sexual crime. The mental deterioration which gradually overcomes many alcoholists may also be connected with various forms of sexual misconduct.

The association of epilepsy and crime has been greatly exaggerated. There is no reason to believe that this form of mental disorder causes the sufferer to indulge frequently in criminal activities. Nevertheless, the conditions of mental excitement, as well as the states of altered consciousness which may occur in the disease, are sometimes related to sexual offences.

The mental deterioration which is associated with senility is frequently related to sexual offences of various kinds, and the previous tendencies of the offender may determine the course of the criminal behaviour. There seems to be no doubt, also, that senile sexuality, finding no accomplice among adults, often expresses itself by indecent assaults upon small girls, who may be willing to take a passive part in a new adventure. Further, criminal misconduct in the sphere of senile sexuality may express itself in less aggressive activities such as indecent letter writing, or the transmission through the post of pornographic literature to strangers or women acquaintances.

Reference may be made here to the fact that although in men an enlarged prostate gland is alleged to be a common cause of sexual crime there is little doubt that the association is much overrated. At the same time it may be noted that a sexual offence sometimes seems to be related to climacteric changes in men as well as in women.

The sexual life of the hysteric has usually a complicated pattern: precocity, repression, extreme flirtatiousness and provocativeness, combined with frigidity and the gradual development with a married partner of an intricate and abnormal emotional relationship is a rather common sequence. Sexual murder may occur in association with hysteria, but sexual offences in hysterics are usually minor in character, for example, indecency. Much annoyance may be caused to innocent persons if the hysteric is a woman who demonstrates the disorder by accusing others—generally men—of indecently assaulting her, or when she floods the district with anonymous letters which often have a gross sexual content. It seems probable that a good deal of criminal conduct amongst hysterics is prevented through the work of Child Guidance Clinics when dealing with early cases of emotional disorder.

Sexual crime is seldom due to obsessional disorder, and clear cut obsessional states are less frequently a cause of criminal behaviour than is often assumed.

The innate emotional trends and character dispositions which result from the inter-reactions of the physical and psychical attributes of temperamentally unstable persons are frequently associated with sexual behaviour. Frank sexual offences occur, but murder, assault, suicide and attempted suicide which are essentially sexual in character are seen in this connection. A double suicide in persons of the same sex is often sexual in origin.

As the demarcation between mental normality and abnormality is often particularly difficult to define in some sexual offenders who are perverted psychopathic personalities, they are included in the subsequent paragraphs.

5. THE SEXUAL OFFENDER

Heterosexuality.—This term is restricted to the normal sexual impulse which is directed towards a member of the opposite sex, and under the heading of heterosexual offences are included cases of sexual interference with girls under the age of consent and on unwilling women, the act being accompanied often by varying degrees of violence. The sexual act may be easily understood, and the manner and circumstance of a sexual offence against women and girls requires no detailed presentation here, since the criminal behaviour is often no more than the transference of normal thought into a criminal activity. Indeed, interference with girls under age is hardly to be regarded as abnormal if they are sexually mature, consenting, and have concealed their correct age.

A sexual murder is occasionally due to a sexual perversion, but is more commonly the result of jealousy and discord. It sometimes terminates a romantic attachment. It may express sexual inferiority and the striving for superiority of the neurotic.

A brief reference to the crime of incest is necessary. It may be accompanied by violence, but is often the result of mutual consent. In appraising the moral turpitude of the act it will be remembered that, although forbidden by modern standards of conduct, it was practised and commended by the cultural sanctions of the ancients whose morality appears to have been no more wanton than our own.

The majority of sexual offences committed by women are con-

connected with prostitution, and the figures given in the statistical section show that the number of male prostitutes who are received into prison as such is small; 5 males and 172 females during the year 1938. As far as this country is concerned, the women prostitutes who are received into prison constitute a collection of very different individuals. Some are depraved and alcoholic, some are mentally defective or psychotic, many are temperamentally unstable, hysterical and suggestible, others are idle, deceitful, and impulsive.

Of 530 women who had lived as prostitutes for a short or long period of time and were submitted to a medico-psychiatric examination at Copenhagen between the years 1931 and 1935, and were between 15 and 46 years of age, 23·2 per cent. were slightly retarded, 19·1 per cent. were retarded (dullards), 6·8 per cent. were slightly feeble-minded (morons), and 0·8 per cent. were imbecile, 22·5 per cent. were pronounced psychopaths, 7·9 per cent. had other mental diseases. Only 29·4 per cent. were mentally normal and without defective intelligence. Those who could not be classed as abnormal were considered to have, in the majority of cases, limited mental capacity or difficult characters. Among both the normal and abnormal Tage Kemp found alcoholism, criminality, workshyness, wanderlust, mental instability, character debility or rudimentary sentiment development. Occasionally hypersexuality and other sexual abnormalities were observed, but none of these was particularly characteristic or frequent.

Concerning prostitution in women only two further matters require notice here; namely, the rapidity and completeness with which the transformation from an honourable girl into a prostitute proceeds, and the incorrigibility of the prostitute which is often the despair of the social worker.

Homosexuality.—This term is applied when the sexual impulse is directed towards a member of the same sex and, as far as crime is concerned, is restricted in practice to men and boys. It will be seen from the statistical section that the majority of homosexual crimes—about three quarters—are minor in character; unnatural offences including bestiality and attempts to commit unnatural offences number about one quarter.

Homosexuality appears to have been practised in all civilisations and amongst all people of whom there is record, but the social attitude adopted towards it has varied very considerably. It has been approved and encouraged at one time and severely

condemned and punished at another. Even at the present time there are some who would only punish offenders who contaminated young people. So too, a homosexual has written: "In a society made charitable by scientific knowledge, the chaste invert (*i.e.* homosexual) would meet from the normally sexed the pity and sympathy given to the disabled instead of the shocked condemnation which is too often his lot at the present time."

It is usual to speak of homosexuality as either acquired or of constitutional origin. This is useful for descriptive purposes, but a clearer view of the condition is obtained if it is regarded as the result of a combination of various causative factors. In a considerable proportion of cases other forms of perverse sexual activity are present as an additional means of gaining sexual pleasure, or another perversion, sadism for example, may occur in combination with the homosexual urge. In our "Report On The Psychological Treatment of Crime", Hubert and I did not find a differentiation into the active or masculine and the passive or more feminine type of homosexual was satisfactory or corresponded with the findings. A homosexual, usually, has as his sexual object a man or a boy of a type confined within quite narrow limits. Sometimes an effeminate type of homosexual has as his object a masculine type, but it was equally common to find that he was interested either in a man like himself or in a boy. There was a sharp demarcation between those homosexuals who had boys as an object and those who were attracted by men; it was uncommon to find a man greatly attracted to both.

A constitutional factor, showing itself as a tendency towards sexual perversion in general is often present. A specific inherited tendency towards homosexuality is also operative, in all probability, in certain cases. It is strongly suggested by the fact that in some families homosexuality recurs in circumstances in which propinquity or common environmental factors seemed unlikely to be the causative factor. It also appeared fairly certain during our investigation that a factor related to the physical type concerned might also play an important part. Youth and good looks would predispose to the development of homosexuality because they would prove attractive to the homosexual in quest of a partner. In our series of 79 homosexuals seduction in childhood or youth was the commonest single environmental factor. This sequence of events appeared most important in the causation of overt homosexuality, and is probably far more likely an explanation than one

which depends upon the assumption that a specific glandular influence acting in a feminine direction is in operation. Undoubtedly feminine physical characteristics may be associated with the condition, and may be attributable to glandular dysfunction, but they are comparatively uncommon.

Summarising the factors which predispose towards homosexuality in men, Hubert and I set out, first, a general tendency towards a varied and primitive kind of sexual outlet; second, in some cases, a specific inherited tendency towards homosexuality; third, a physical type which predisposes towards early seduction by homosexuals, which may be regarded as the fourth factor and the most important of the environmental causes.

More general environmental factors are racial and social conditions which lead to the development of homosexuality. In our present civilisation encouragement has never been overt, but circumstances often have had the same effect; for example, boarding schools, and social or religious movements in which there is close association between members of the same sex, act in this direction. In certain families the attitude of the parents—for example, those who desiring a daughter bring up the son as girlishly as possible, or the widowed mother who, through her entirely feminine influence, has much the same effect—tend to produce homosexuality in their sons by fostering tendencies perhaps already present, but, as already shown, by increasing the chances of homosexual seduction also.

Other environmental factors, by rendering more difficult or unpleasant heterosexual life, lead to the development of homosexual tendencies. Venereal disease and severe emotional suffering caused by a woman may both act in this way. So, also, will influences which destroy acquired cultural standards erected against homosexual tendencies. Grave functional disorder, such as schizophrenia, and organic cerebral deterioration through senile or arteriosclerotic changes may be operative, as may the more temporary interference with moral control resulting from chronic alcoholism and some other drug addictions.

The tendency towards homosexual interest may be realised for the first time at any age. In the above mentioned series the earliest homosexual activity remembered occurred at the age of four years. In some cases the discovery will not be made until the patient is forty years of age or more. If the activity is released by organic brain disease the offender may be over sixty years of age. But in

the majority of cases, although the individual may not have been aware of their implication, he will be able to remember dreams or phantasies occurring from early life which have had a homosexual significance. Occasionally, it seems to be true that the offender did not realise his homosexual tendency until it was transferred into criminal activity on a sudden impulse. It may be first declared during a state of alcoholic intoxication. Many persons practise, either in reality or phantasy, other forms of perverse activity, usually sadistic or masochistic in form.

There is no reason to regard homosexuality and heterosexuality as necessarily antagonistic. In one case, which came under my notice a sadistic murder was committed by a homosexual, the victim being his male paramour. Some years before the homicide had attempted to persuade his newly married wife to allow a youth, with whom he had a physical and emotional attachment, to accompany them on their honeymoon. She refused, and the marriage was consummated from time to time, although homosexual performances remained the chosen method of the husband's sexual activity.

In ordinary life many environmental factors are in favour of heterosexual interest. This may survive in the pervert and lead him away from homosexual activities. It is also true that just as heterosexuality can develop on the highest and most complicated ethical plane so can homosexuality. The homosexual who develops in conformity with the culture in which he lives and remains chaste, may be as blameless as the ordinary man who remains continent in spite of heterosexual temptations. Indeed, sexual life in the former is often more complicated, sublimated and specialised than in the latter.

According to the usual view homosexuality is unrelated to other forms of sexual perversion, and is due to environmental influences combined with a constitutional factor predisposing towards femininity which may be glandular in origin. The view put forward by Hubert and myself, and quoted above, has practical consequences, for it does not restrict psychotherapeutic treatment to cases who have the fewest feminine characteristics.

It is sometimes suggested that the association of other sexual perversions and of more general asocial and antisocial activities with homosexuality is due to the fact that they are ostracised and punished, and so offenders of this type become associated with other law-breakers. That this is only relatively true is shown by

the investigation of women homosexuals against whom the social ban is less vigorous. Such an investigation carried out by Hubert on an unselected group of women homosexuals as well as various other studies upon female offenders, prostitutes and others showed that women homosexuals, as a group, have many characteristics which may be regarded as perverse and asocial in considerable excess of those shown in a heterosexual group. It should be added that some homosexual women are good wives and mothers and are not insensible to normal love though they prefer homosexuality. Sofie Lazarsfeld believes women are less affected by homosexuality than men "for whereas male homosexuals live in constant fear of the law and are also frequently blackmailed, female homosexuals are left alone by the law".

Exhibitionism.—This term is used to denote cases of indecent exposure and to emphasise the psycho-physical purpose of the act. Indecent exposure was the commonest class of sexual offence in males in a series of 291 sexual offenders examined by me whilst they were on remand or awaiting trial at Brixton prison some twenty years ago—107 offenders in this series were under observation for this offence. It will be seen also in the statistical data above that it is still the most frequent single sexual offence committed by men.

Offenders who show exhibitionist behaviour usually have a history of autoerotic behaviour from the age of puberty or even before. The step from this towards indecent exposure to passing women in a relatively unfrequented place, is not, in some men, a very great one. The increased excitement thus obtained becomes a desirable addition to autoerotic satisfaction, and soon becomes a habit which is readily enjoyed in conditions of increased sexual feeling.

Additional factors which increase the probability of the habit developing are the presence of a general tendency towards sexual perversion, a disposition which leads to irresponsible behaviour, lack of moral control, and petty crime which may be based upon mental defectiveness or imperfect emotional development in social relationships. Occasionally the pressure of some local physical abnormality may also predispose towards exhibitionism. Habit appears to be of the utmost importance in this class of offender. Physical satisfaction becomes so closely associated with this particular form of sexual indulgence that often it persists after marriage although perfectly normal sexual relations are

also established. As Hubert and I pointed out the reason why the habit is so easily formed and becomes so powerful is probably because it is so closely linked with the most primitive form of sexual activity—autoeroticism—and that it allows a certain amount of heterosexual enjoyment to be experienced through the phantasies which are concerned with the activity. Also, it is extremely easy to carry out with no great chances of arrest.

Some exhibitionists prefer this method of releasing sexual tension to any other, and practice it repeatedly over many years. Others fight against the temptation and are anxious to have it removed. Some use it for solicitation, some through fear of ordinary sexual relations or of venereal disease, and some because they are unable to obtain normal heterosexual relations. In a few it may be an isolated act due to a sudden temptation when an opportunity is unexpectedly presented; in not a few it is the result of loss of self control through alcoholic intoxication, and the desire to urinate may suggest the activity. It may be the result of mental disease, mental defectiveness or the psychoneuroses. In many cases a history of heterosexual play in childhood is common and may remove at an early age the barrier between the sexes and so predispose to exhibitionism. In some homosexuals indecent exposure to other men may be a commercial solicitation, but examples of true homosexual exhibitionism occur.

The sexual object of the typical heterosexual exhibitionist is fairly well fixed. She must be a stranger, sometimes more than one person must be present, and her age must be fairly constant, girls of a particular age are sometimes essential. In the ordinary heterosexual relationships exhibitionists show no tendency to enjoy exhibitionism on the part of their partner, nor do they then tend to exhibit themselves.

The impulsive quality of exhibitionism is usually clearer than in other types of perversion or in any other, except very rare, types of crime. The exhibitionist often becomes seized with an ever increasing urge to carry out his wish, and this may ultimately overwhelm him. Usually, there is no anxiety, but this may appear in men who are constitutionally predisposed to become anxious in situations of tension. The pleasurable aspect of the act may be obscured by a feeling of agitation which is only relieved at the time of actual exposure. In such cases the urge is complex and other objects in carrying out the performance can be demonstrated. The universal obsessional characteristic appearing in

comparable situations, the tendency to balance one thing against another—in an extreme form the, so-called, “doubting-mania”—is absent. As soon as the temptation is yielded to the whole personality participates. There is no suggestion of a separation off of a morbid part of the mind such as is found in the obsessional patient against which the healthy part can be set up and even obtain an objective attitude. At the most the exhibitionist will make a conventional distinction between his “good” and “bad” impulses.

The obsessional subject usually shows evidence of a long standing obsessional activity before asocial or antisocial conduct is declared. In the great majority of cases investigated in the Report on The Psychological Treatment of Crime this type of personality did not occur in the exhibitionist—there was one exception in the 35 cases examined, nor were occasional obsessional symptoms at all common.

The sexual feeling in the exhibitionist and the practice correspond quantitatively with those of the average man. There appears to be no tendency for exhibitionism to be associated with either hypersexuality or hyposexuality, and in many cases the exhibitionist who wishes to overcome his perversion will find he is able to restrain himself from criminal behaviour if he never goes out alone.

Sadism and Masochism.—The term sadism is used here for activities which enable sexual satisfaction to be obtained by inflicting pain, and masochism for activities which enable sexual satisfaction to be obtained by suffering pain. The infliction of cruelty without sexual relationship may result in pleasure by satisfying revenge, hatred or other degrading impulse, and the infliction of suffering on oneself, or seeking situations which enable others to inflict suffering upon one, may have the same effect. But to include under the heading of sadism and masochism conduct which is pleasurable in a non-sexual manner would obscure the issue in the present context, as would the inclusion of the more abnormal and complicated situations and conditions arising through mental disease, or any grossly abnormal emotional behaviour pattern from whatever cause other than sexual.

In sadism and masochism considered here, the cruelty or bearing of pain not only gives definite sexual satisfaction, but is in itself the sexual aim. The cruelty is sometimes self-inflicted. Sadistic or masochistic motives may appear in the material pre-

sented by many kinds of criminals but, except in the perverts defined above, will rarely appear as the most important causative factors of the offence or the most striking features of the offender's emotional life.

Havelock Ellis considered sadism and masochism were based on normal human impulses and reinforced weak impulses, and that they were the extreme term of tendencies which in a slight degree were strictly within the biological sphere. He considered that they often existed separately and that it was rare to find a sadistic-masochist, but common to find an element of masochism in the sadist.

Hirschfeld regarded sadism in man as a heightening of the normal sexual attitude and masochism in a woman as a heightening of the normal female sexual attitude. Iwan Bloch, discussing sadism and masochism, says: "It is certain that we have here to do with an anthropological phenomenon, and that it is normal within wide limits."

Stekel looks upon sadism and masochism as a definite form of psycho-sexual infantilism, the sexual energy of the masochist being passively directed, that of the sadist actively. He says, however, "It will not do simply to compare with each other the ideas masculine—sadistic and feminine—masochistic, although this point of view apparently gains support through many manifestations of sexual life." He considers sadism and masochism to be a disorder of environment and to be referable to definite influences in childhood.

Freud stated in his *Three Contributions to the Theory of Sex*: "The sexuality of most men shows a taint of aggression, it is a propensity to subdue, the biological significance of which lies in the necessity of overcoming the resistance of the sexual object by actions other than courting. Sadism would then correspond to an aggressive component of the sexual impulse which has become independent and exaggerated and has been brought to the foreground by displacement." He states in another passage: "A sadist is simultaneously a masochist, though either the active or the passive side of the perversion may be more strongly developed and thus represent his preponderate activity."

W. McDougall pointed out that Freud in his later work, *Civilisation and Its Discontents*, regards sadism and masochism as two opposite modes of working of the death instinct, whereas McDougall regarded them as the impulses of the two opposed but independent instincts of self-assertion and submission respectively.

He referred to Freud's death instinct as "the most bizarre monster of all his gallery of monsters".

The great majority of sadists and masochists are true sexual perverts and show marked evidence of the sexually perverted type of constitution. Most of them show in phantasy or performance both sadistic and masochistic tendencies, but one or other predominates. As stated previously several perversions may co-exist.

The reasons that led to the development of this abnormality are often difficult to determine, but probably they are in all cases specific and environmental. Many remember gaining sexual pleasure from phantasies of this nature in early years, and very often remember pleasure obtained from actual performances. Contact with others with similar, or opposite tendencies and certain types of story also have a direct influence. A child thinks of human relations so much in terms of like and dislike, friendship and enmity, kindness and unkindness, physical caress or cruelty that the developing sexual feeling readily associates itself with the dramatic form of these attitudes. It is a well-known finding also that children who are ignorant of inter-sexual relations will, upon learning something of it, associate it with sexual feeling in themselves and the conception of a violent attack by the man on the woman.

Further, various abnormal personality types who tend to associate sexual feeling with excretory or instinctive activities, also tend to develop sadistic or masochistic interests. Individuals who through constitutional factors or unfortunate experience develop very strong aggressive drives, such as resentment or antagonism tend to associate them with sexual feeling developing at the same time and with a similar result.

A sadist, when his confidence is gained, readily admits that he obtains sexual pleasure from the act. As pointed out by Hubert and myself this seems essential for diagnosis. The only exception is when there is a very strong reason to assume that sexual excitement was present although the individual cannot afterwards verbalise the fact that it was present physically or mentally: for example, if he has frequently obtained sexual pleasure from phantasies similar in content to the activity. To extend the term to cover cases in which sexual feeling may have been present in this way raises questions of the exact meaning of "unconscious" sexual pleasure, and of the right to identify interpretation with material actually presented by the subject.

Sadism may result in murder, attempted murder and assaults, in the defilement of a woman's costume in the street by splashing it with ink, etc. In one case in which I was concerned two women were murdered and four others were seriously assaulted before the sadist was arrested. The literature contains records of several murders having been committed by the same man, the specific activity being the sexual excitement aroused by the killing and subsequent mutilation of the dead body. Although ordinary sexual contact may take place in such cases it is unusual and of secondary importance to the sadist.

The sadist may select his victims from either sex. Although they are usually of the same sex as each other they may be of widely different ages. The degree of violence used often appears to depend upon the celerity with which the sexual tension of the aggressor is relieved. The more extreme the violence used the more likely is it to be associated with a pathological mental state.

Masochism is usually far less simple in its manifestations. In its typical form an elaborate ritual is carried out, and itself gives final sexual pleasure because the individual is beaten, bound, fastened, defiled or humiliated by a member of the opposite sex or by himself. It is frequently combined with other perversions such as transvestism, fetishism, etc., and may occur in homosexuals. In some cases, in which the masochist has frequently carried out previously an elaborate ritual which enabled him to commit suffering on himself, death has resulted through misadventure in fulfilling the details of the performance.

Certain other offences, notably arson and theft are related to the sado-masochistic group of offenders. Hubert and I have reported a case of arson of this type. I have known a woman steal articles from a London Store in order to obtain sexual relief by raising the emotional tension through fear of detection during the act. H. Zingerle and others quote cases which appear to have a like nature.

Sado-masochistic practices appear to be more attractive to some women than is sometimes supposed,¹ and technical difficulties may arise at the trial. In *Rex v Donovan* it appeared that the defendant was a sadist and made suggestions to a girl which if

¹ In one case that came under my observation the sadist had no difficulty in obtaining "victims". According to his statement, which was supported to some extent by the evidence, only one out of several girls refused his invitation, all the others consented to take part in a rather elaborate ritual which culminated in gross violence. The girls were not public women.

taken seriously meant that he intended or desired to beat her. According to the evidence of the defendant, and that of a young woman who said that she had overheard some of the telephone conversation, there was talk between the defendant and the prosecutrix which left no doubt that she had expressed her willingness to submit herself to the kind of conduct to which he was addicted. The defendant was convicted at Quarter Sessions of assault in that he beat the girl with a cane. The conviction was quashed by the Court of Criminal Appeal on the ground that there was a misdirection to the jury in regard to the consent of the prosecutrix since in the absence of facts which proved the act to be unlawful in itself the defendant could be convicted only if the prosecution negatived consent. In regard to the assault the Court of Criminal Appeal declared that: "If an act is unlawful in the sense of being in itself a criminal act, it is plain that it cannot be rendered lawful because the person to whose detriment it is done consents to it. No person can licence another to commit crime. So far as the criminal law is concerned, therefore, where the act charged is in itself unlawful, it can never be necessary to prove absence of consent on the part of the person wronged in order to obtain the conviction of the wrongdoer. There are, however, many acts in themselves harmless and lawful which become unlawful only if they are done without the consent of the person affected. What is in one case an innocent act of familiarity or affection may in another be an assault, for no other reason than that in the one case there is consent and in the other consent is absent. As a general rule, although it is a rule to which there are well-established exceptions, it is an unlawful act to beat another person with such a degree of violence that the infliction of bodily harm is a probable consequence, and when such an act is proved consent is immaterial. We are aware that the existence of this rule has not always been clearly recognised." The Court then referred to well-established exceptions and continued: "In the present case it was not in dispute that Donovan's motive was to gratify his own perverted desires. If in the course of so doing he acted so as to cause bodily harm, he cannot plead his corrupt motive as an excuse. . . . Always supposing, therefore, that the blows which he struck were likely or intended to do bodily harm, we are of the opinion that he was doing an unlawful act—no evidence having been given of facts which would bring the case within any of the exceptions to the general rule. In our view, on the evidence given at the trial, the

jury should have been directed that if they were satisfied that the blows struck by the prisoner were likely to be intended to do bodily harm to the prosecutrix, they ought to convict him, and that it was only if they were not so satisfied that it became necessary to consider the further question whether the prosecution had negatived the consent. For this purpose we think that "bodily harm" has its ordinary meaning and includes any hurt or injury calculated to interfere with the health or comfort of the prosecutor. Such hurt or injury need not be permanent, but must no doubt be more than merely transient and trifling." (*The Times* Report. July 28th, 1934.)

Fetishism.—The term fetishism is applied in different senses, varying from a usage which corresponds to that of the term sexual perversion itself to one which confines it to those cases in which sexual interest is mainly centred on an inanimate object, or merely a portion of an individual. It is used here, arbitrarily, in the latter sense. This corresponds rather closely to the use of the word in the non-sexual sphere.

Slight degrees of fetishism are, of course, entirely normal. Every lover tends to become attracted to some individual feature of the person he admires, or to some of the various articles that come into contact with her. This tendency becomes abnormal when the individual feature or inanimate object is divorced from the rest of the personality which it replaces, and itself becomes the exclusive sexual object.

The fetishist may commit burglary, theft and assault in order to provide himself with the required article of female clothing, and some fetishists find the garment must be stolen if full satisfaction is to be obtained. The shoe or hair-cutting fetishist is occasionally seen in the criminal courts, and in one case a lad was investigated who obtained sexual pleasure from collecting, making and playing with knives.

Transvestism.—Sexual pleasure derived from wearing female garments may be obtained in various ways. Transvestites proper are those who obtain sexual gratification by pretending to be, as well as by dressing up as, a member of the opposite sex. In appearance, manner and interests the male transvestites appear to be more feminine than masculine. It is found that, as children, their play and general behaviour was girlish, and as they grew older they preferred feminine rather than masculine occupations, and association with women rather than with men. They may show no

sign of sexual interest in their own sex and early homosexual seduction did not occur in the transvestites investigated by Hubert and myself. The male transvestite may be arrested by the police for an offence in a non-sexual field, but an apparently non-sexual offence such as burglary or theft may be committed by him in order to obtain articles of female attire.

Other types of Perversion.—Bestiality is a not uncommon offence in some rural areas. Pornographic offences are occasionally due to perversion. The rarer forms of sexual perversion met with in the criminal courts need no special mention here.

6. TREATMENT

It cannot be denied that our present methods of dealing with the sexual offender are often unsatisfactory. The first prerequisite is a better general understanding of normal and abnormal sexuality. Next in importance is the preliminary medical examination of the sexual offender by an experienced psychiatrist. This investigation will determine whether insanity or mental defectiveness is present; and whether the offender is a suitable case for action under the Lunacy or Mental Deficiency Acts. It will enable a decision to be reached as to whether the offender is suffering from a psychoneurosis or other psychopathic state which although uncertifiable under the above Acts may be amenable to psychotherapy, but it cannot predict whether the treatment will be successful. One of the initial difficulties in the psychological treatment of sexual offenders lies in the fact that many of them are unwilling to risk a modification of their perversion unless an alternative and equally satisfactory method of sexual gratification can be acquired. The third prerequisite is close collaboration between the courts and the psychiatrists. In some areas valuable work is being done by accredited clinics in the diagnosis and treatment of sexual offenders, and in the adjustment of potential offenders to social life.

Apart from the limitations of psychological treatment is the fact that the Court must consider its duty to society as well as to the offender. Society may not be effectively safeguarded if a sexual offender is responsible in law but receives a non-custodial sentence merely because he is abnormal. On the other hand, a severe custodial sentence cannot be justified for a minor sexual offence merely because the mental condition of the offender is believed

to require prolonged medical treatment. We are here faced with one of the dilemmas of penal reform to which Dr. Hermann Mannheim has recently called attention in his admirable book on the subject.

The reconviction rates of five groups of offenders were given in the statistical data above, and the sexual offenders did not compare unfavourably with the other groups. In suitable cases probation, psychotherapy or imprisonment may prove effective in preventing further sexual crime. But there are many failures:

A youth aged 22 was sentenced to 12 months imprisonment for indecent assault. At the age of 14 he was fined for wilful damage, and six months later for housebreaking, and was placed on probation. Two years later he was sent to an approved school for indecent exposure, and has since then been placed on probation or sentenced to imprisonment five times for fifteen similar offences—four, three and two separate offences being taken into account on three successive convictions. He received psychotherapeutic treatment during two sentences of imprisonment, but this has not affected his conduct materially, neither has probation or imprisonment. He is not insane or mentally defective, he does not suffer from the obsessional neurosis. His conduct is the result of an early-formed habit which has become associated with a compulsive element.

The Criminal Justice Bill, 1938, suggests that improved facilities be given to courts of summary jurisdiction in England and Wales to obtain a medical report on the mental condition of an offender in order to assist the court in deciding how to deal with him by remanding the prisoner on bail with a requirement that he submits himself to medical examination, and provides for payment of the cost of the medical examinations at approved institutions or by approved persons. At present it is usually necessary to remand the accused in custody so that he can be examined by the prison medical officer.

A further proposal is that probation orders may include a provision regarding offenders who, though not certifiable as insane or mentally defective are suffering from some form of mental illness or abnormality which is susceptible to treatment, to submit themselves to mental treatment, the payment for such treatment to be part of the expenses of the probation committee.

In addition to the remand homes provided already by local authorities under the Children and Young Persons Acts for per-

sons under the age of 17, the Bill proposes the provision of State Remand Homes for persons under 17 who require special medical observation, and the provision of special institutions to be called Remand Centres to which young offenders remanded or committed for trial in custody are to be sent instead of to a prison. The Remand Centres are to serve the purpose of observation as well as custody and will be for persons between the ages of 17 and 23 and persons aged 14-17 years who are certified by the court to be of so unruly or depraved a character that they cannot be detained in a remand home.

The Report on the Psychological Treatment of Crime recommended that a new form of institution for convicted offenders should be established under the administration of the Prison Commissioners in which psychiatric and psychological treatment of abnormal sexual and other offenders, who were not certifiable under the Lunacy or Mental Deficiency Acts, could be carried out. Some unimprovable cases would benefit also by detention in such an institution, for their conditions of training and general treatment could be modified in a manner which is impracticable in an ordinary prison. The war has prevented any progress on these lines, but the Annual Report of the Prison Commissioners for the year 1938 visualised the establishment of such an institution.

A proportion of sexual offenders are recidivists who do not require detention in a special penal institution but from whom the public require to be protected. The Criminal Justice Bill, 1938, proposes to substitute provisions enabling Courts of Assize and Quarter Sessions in England and Wales and the High Court of Justiciary and the Sheriff Court in Scotland, to pass, in lieu of, and not in addition to, sentences of imprisonment or penal servitude, two new types of sentences:

(a) Sentences of corrective training for a period of not less than two and not more than four years on persons between twenty-one and thirty years of age whose records, characters and habits are such as to make such a sentence expedient for the training of offenders; and

(b) Sentences of preventive detention for a term of not less than two and not more than four years on persons over the age of thirty, if by reason of the offenders' criminal antecedents and mode of life such a sentence is expedient for the protection of the public. For certain types of offenders with records of repeated

crime it is proposed that such sentences may exceed four but shall not exceed ten years.

If these proposals, and the various other measures outlined above, are implemented, society will be thereby better protected than at present, and the welfare of the sexual offender will be better served.

LIST OF REFERENCES

- ANOMALY. *The Invert*. London 1927.
- The Annual Report of the Prison Commissioners*. H.M. Stationery Office, 1938.
- BENTHAM, JEREMY. *The Theory of Legislation*. Eng. translation. London 1931.
- BLOCH, IWAN. *The Sexual Life of Our Times*. Eng. Edit. London 1924.
- COLEMAN, S. M. "Review." *Journal of Mental Science*, Vol. LXXXVI, No. 364. Sept., 1940.
- The Criminal Justice Bill*. H.M. Stationery Office 1938.
- The Criminal Statistics*. H.M. Stationery Office 1938.
- EAST, W. NORWOOD. *The Medical Aspects of Crime*. London 1936.
- EAST, W. NORWOOD. "Responsibility in Mental Disorder with Special Reference to Alcolagnia." *Journal of Mental Science*. Vol. LXXXIV, No. 348, Jan., 1938.
- EAST, W. NORWOOD; and HUBERT, W. H. DE B. *The Psychological Treatment of Crime*. H.M. Stationery Office 1939.
- EAST, W. NORWOOD. "Observations On Exhibitionism." *The Lancet*. Aug. 23. 1924
- ELLIS, HAVELOCK *Psychology of Sex*. Philadelphia 1933.
- FREUD, SIGMUND. *Three Contributions to the Theory of Sex*. 2nd Ed. Washington 1920.
- HENTIG, HANS VON. "Interaction of Perpetrator and Victim." *Amer. Journal Criminal Law and Criminology*, Vol. XXI, No. 3. Sep.-Oct., 1940.
- HIRSCHFELD, M. Quoted by Havelock Ellis in *Psychology of Sex*. 1933.
- HULBERT, HAROLD S. "Psychiatric Reports in Court." *The Journal of Criminal Law and Criminology*, Vol. XXXI, No. 6. March-April, 1941.
- KEMP, TAGE *Prostitution*. Copenhagen and London 1936.
- LAZARSFELD, SOFIA. *Woman's Experience of the Male*. London 1941.
- MANNHEIM, HERMANN. *The Dilemma of Penal Reform*. London 1939.
- MCDUGALL, W. *Psychoanalysis and Social Psychology*. London 1936.
- NEWMAN, CARDINAL. *Idea of A University*.
- PUTNAM, J. J. *Addresses on Pschy-Analysiss*. London 1921.
- STEKEL, W. *Sadism and Masochism*. 1935.

STEPHEN, JAMES FITZJAMES. *Digest of Criminal Law*. 7th Edit. London 1926.

THOINOT, L.; and WEYSSE, ARTHUR W. *Medico-Legal Aspects of Moral Offenses*. Philadelphia 1920.

ZINGERLE, H. "Contributions to the Psychological Genesis of Sexual Perversities." *Annual for Psychiatry and Neurology*. 1900.

X

CERTAIN ASPECTS OF JUVENILE DELINQUENCY

I. PHYSICAL AND MENTAL FEATURES OF THE JUVENILE DELINQUENT

By DR. J. D. W. PEARCE

WHEN Cesare Lombroso's theory that criminals possess certain well-defined physical characteristics differentiating them from other humans came to be discarded, there developed a tendency to ignore altogether the significance of constitutional factors in the aetiology of anti-social conduct. More recent observation has demonstrated clearly that organic variations from the average are important factors in the genesis of delinquency.

Experience of many thousands of juvenile offenders reveals the fact that in the majority of cases they are of less sturdy and robust physique than the average child. Slender, asthenic persons occur with greater frequency in the delinquent than in the non-delinquent group. The former group shows a greater incidence of sub-normal nutrition and inferior musculature; of minor skeletal deformities such as slight spinal curvature, pigeonchest, knock-knee and flatfoot, in many cases the residual effects of rickets in early childhood; of carious teeth, unhealthy tonsils and adenoids, and visual defects of significant degree. In themselves these conditions do not account directly for the disturbance of behaviour; but, in that they involve an increased susceptibility to physical and mental fatigue, and a lessened capacity to compete on equal terms with their neighbours, they reduce the prospect of achieving success and happiness in everyday life.

Certain more obvious, but less frequent disabilities may be related causally to the aberrant conduct. Of these the more common are diseases of the heart and lungs which so restrict the child's activities that he is debarred from joining in the games and the gang life of his associates; furthermore, awareness of the affliction may seriously disturb the emotional stability and equanimity of the child. The child endowed with a neuro-arthritic diathesis, *i.e.* a psycho-physical pattern especially prone to rheumatic heart

affection and chorea, is of a restless, unsettled nature and tends to be discontented and fretful; in some cases this diasthesis is a vital causal factor in delinquency.

There are certain specific disabilities the presence of which often remains unobserved, which, though by no means common, nevertheless may be closely related causally with the faulty conduct. The discovery that he is colourblind may seriously thwart a lad's ambitions, and, disappointed and discouraged, he may embark on a phase of delinquency. Congenital wordblindness, an inability to see words, due to an anomaly of development of the brain tissues, results in school failure, misguided reproof and consequent truancy; moreover, the child is denied access to all the riches which literacy yields, and it is no wonder that his feet enter on the path of delinquency. Deafness, even though it be of small degree, isolates a child from society, and he may seek compensatory satisfactions. Defects of speech, in addition to the obvious handicap which they impose, tend to provoke ridicule and weaken the child's link with normal society. These disabilities are constant, and in some cases irremediable obstacles to educational advancement and economic progress and security. Incontinence of urine is frequently due to an underlying psychoneurosis, but whatever the cause, the very disability implies a sense of social reproach and must be concealed; the child's place in society is imperilled. Lefthandedness is a well-known anomaly, and is of no significance unless efforts are made to convert it to righthandedness. Such ill-advised endeavours may result in serious instability, distress and conduct disorder.

By no means all children with afflictions such as these are delinquent. In practice it is rare to find delinquency of such direct, uncomplicated aetiology; but in so far as such conditions impair the child's success in society they create situations from which delinquency may emerge.

There is also a small group of organic diseases of the central nervous system which directly affect a person's conduct. The most common of these are encephalitis lethargica, meningitis, epilepsy and congenital syphilis. Encephalitis lethargica, or sleepy sickness, is an inflammatory disease of the brain tissues, and it may cause structural damage so grave and irreversible as to alter profoundly the temperament and personality of the child; *e.g.* a formerly good child becomes apache. Obvious cases of this disease display characteristic bodily signs, but many cases are much less

distinctive and may elude detection. Meningitis, which is an inflammatory disease of the tissues which invest the brain, is in my experience rarely a cause of delinquent conduct, though it is frequently claimed so to be. A claim to have suffered from meningitis is rarely to be trusted unless reliably corroborated. Epilepsy, a condition of unusual personality commonly associated with convulsions, is only rarely a cause of delinquency in children. It is, however, a very popular screen behind which the offender tries to shelter. It is unusual for the delinquent conduct to be due to this malady even in those children known to be epileptic. Congenital syphilitics are usually amiable and law-abiding, but may lapse into delinquency either as a result of organic brain damage or as a reaction to the unwelcome attention which their characteristically deformed features excite from society.

The responsibility for many features of human economy and conduct has been attributed to the endocrine glands; it is only very rarely that disorder or imbalance of endocrine activity, *e.g.* thyroid and pituitary, occurs or is significant in a child with conduct disorder. Such cases in children are usually obvious to the layman in that they are the oddities of the human race. The majority of children so afflicted are usually docile and well-behaved, and in those who are delinquent the aetiology of the behaviour pattern is mainly complex.

A child's height and size may be exploited with delinquent intent. A tall, strongly built youth can indulge in violence; a Tom-thumb, slender lad can find his way into premises, entry to which defeats his bigger companions. In general, a child's physique and development should be appropriate to his age. Any pronounced variation discriminates him from other members of his age group, and the significance of this as a possible factor in motivating the delinquency should be assessed in any such case.

Any physical attribute or constellation of such attributes may be regarded in a variety of ways by its possessor. It may be an asset to be exploited; a handicap demanding compensation; or an agent to inhibit development and activity. From such simple points of departure complex disturbances of behaviour can develop.

The number of juvenile delinquents in each year age-group increases rapidly until school leaving age, when there is a decline followed by sharp increases in the sixteenth and succeeding years. In adolescence, there is a phase of rapid physiological change and

development characterised by a temporary deterioration in higher brain function, emotional and endocrine imbalance, enhanced instinctual activity, diminished muscle co-ordination and manual dexterity, together with a vague sense of inferiority. Quite often there is an obvious and irksome phase of lethargy. These phenomena are physiologically determined, and a concomitant may be thoughtless and foolish conduct. In adolescent girls the early onset of puberty and the precocious development of feminine attributes are features conducive to sexual delinquency.

The delinquent is commonly apathetic in the care of his body. He is more commonly infested by lice and has similar unclean diseases than his law-abiding neighbour. This is due both to his delinquent traits of character which leave him unruffled by verminous contamination and to his coming from a socially inferior milieu.

In summing up one may say that juvenile delinquents are more often of inferior stock than their comparable non-delinquent neighbours; and more often of a relatively faulty nurture. The physical inferiority of the delinquent is quite definitely due in some degree to inferior heredity, but in a large degree it is the outcome of faulty nurture and can be prevented.

The possession of an adequate mental endowment is an important asset in wellnigh every walk of life. The child's intelligence grows steadily until the fifteenth year whereafter there is but little further development. Systematic assessment of the general mental development of the members of any age group reveals an unequal distribution of intelligence. The majority approximate closely about the mean, from which there is a gradual tapering off towards the upper and lower ends of the scale. The child whose assessment equals the mean of, say, the 12-years age group has a mental age of 12 years. It is convenient to use the term Intelligence Quotient or, briefly, I.Q.

$$\text{I.Q.} = \frac{\text{Mental age}}{\text{Chronological age}} \times 100.$$

The mean I.Q. is 100. The limits of the "average" I.Q. are 85 and 115. An I.Q. greater than 115 indicates superior intelligence, whereas I.Q. 70-85 comprises the dull and backward group. Still lower, I.Q. 50-70 indicates feeble-mindedness. Those whose I.Q. is less than 50 usually require segregation under certificate. There are, however, no sharp lines of demarcation between

these categories, but rather a gradual merging of each into the next.

A highly significant observation is that the average I.Q. of a true sample of delinquent children is only 84, and the distribution about this mean is very similar to that of the unselected group about the mean of 100. Though small, the percentage of children in the delinquent group who are certifiably mentally defective under the Education and Mental Deficiency Acts is several times greater than in the unselected group. This relative constitutional inferiority immediately places the average delinquent child in a subcultural class of society. This inferiority is an irremediable relative handicap both at school and later in the economic struggle. The prospect of success for a child of inferior I.Q. is patently less than that of his average rival competitor. Many juvenile delinquents are law-abiding so long as they are not economically pressed.

Specific aptitudes or talents are exploited naturally by the child in the need to find expression and achieve success. These specific facets of intelligence vary greatly in their distribution. Two such factors are perseverance and fluency. Perseverance needs little further elaboration; most delinquents are singularly lacking therein. Fluency, especially verbal, often serves to conceal a relative poverty of mind; this type of child tends to become an incorrigible liar, a professional beggar or confidence trickster.

The juvenile delinquent's I.Q. correlates highly with the quality of the offence. Where the dull and backward youth breaks open the gas meter in his own home, his intelligent companion will devise an ingenious fraud. The repetition after discovery of the former type of offence is strongly suggestive of mental deficiency.

Educational attainment is an acquired asset. The majority of delinquent juveniles acquire educational attainment not only very inferior to that of the comparable average child, but far below that proper to their own mental age. This failure of achievement is an obstacle to further achievement in the economic sphere; it is also indicative of an undisciplined mind. Low I.Q. and educational failure combine to result in inability to compete on equal terms with others, and the child tends to seek by delinquent methods the gratifications denied to him in other ways.

The significance of temperamental endowment is still the subject of discussion. While there is a growing consensus of opinion that emotional and temperamental factors are of vital importance

in the aetiology of juvenile delinquency, the relative degree to which the responsible factors are constitutional or acquired is still in dispute. Observers such as Jaensch and Kretschmer have drawn attention to the close relationship between certain types of physique and varieties of temperament. It has already been noted that many delinquents are of an asthenic physique, but this is in any event a common physical type, and in the delinquent the frequency of rickets and similar influences introduces an exogenous determinant. Delinquency appears not to be linked with any such recognised psychobiological type.

The writer's experience with many thousands of juvenile delinquents is that one becomes increasingly aware of a high frequency of a quantitative defect in general temperamental endowment. In personality they lack vigour, robustness and colour. Some degree of apathy is usually present and the general stability is inferior. There is an inadequate general integration of the personality. In many delinquent children the reverse is, of course, true, and the very quality of their exploits indicates dynamism. One would expect defect of intelligence to correlate highly with defect of temperamental stability and in the majority of cases this holds true.

At this point it is timely to observe that only some of the children of the types discussed become delinquent; but, given other conditions, such children resort to delinquency more readily than the average or ordinary child.

It is not proposed to discuss in any detail the imperfectly charted fields of instinctual urges and willpower, but in the delinquent child these tend to be weaker, more erratic and less reliable than in the law-abiding community.

The general intellectual and temperamental pattern so far described is seen very commonly in the young prostitute, and in her, too, the importance of character traits is most patently evident. Character, *i.e.* sentiments, standards of conduct including self-criticism and guilty-feeling, and faith, is an acquired attribute of the personality. Its development is the result of interaction between experience and constitutional endowment. The intricacies of experience cannot now be discussed. Let it suffice to say that the vast majority of delinquent children fail to develop any genuine or lasting sense of wrongdoing. They may fear the external policeman but they are untroubled by any internal policeman, *i.e.* conscience. It is very improbable that there is much conscience

or sense of social responsibility in a recidivist; and where such is not developed firmly during the early school years its inculcation later is a formidable task. One may interpolate that the lad who steals a motor car for joy riding is in reality not an adventurous youth, but in the great majority of cases a singularly confirmed, conscienceless, delinquent character. The investigator should not be misled by the young offender's protestations of remorse which are mainly tribute to the probity of the former. In examining any series of juveniles making their first court appearance there are few in whom a long history of delinquency cannot be disclosed. Where there exists in a recidivist a genuine sense of guilt and shame, a psychoneurotic genesis of the delinquency should be sought. This applies by no means only to sexual offences, but also to offences of aggression, offences against property, vagrancy and truancy.

From this brief summary of the physical and mental soil wherein delinquent habits grow most readily, it is evident that there are still other factors which result in one child becoming delinquent in conduct while another, similarly endowed, remains a law-abiding member of the community.

The occurrence of delinquency appears with remarkable frequency to depend on the balance between positive character values and emotional dissatisfaction and stress. Where the character is poorly developed the emotional disturbance resulting in delinquency need be only of small degree. Conversely, where the character is rich and sound, severe emotional stress is necessary to provoke anti-social conduct. The failure to develop good character is largely due to social weaknesses dependent on social sanction, social tolerance and social indifference all of which are remediable. Healy and Bronner have shown that the most dynamic factor in causing delinquency is the subjective side of the delinquent's life, *i.e.* his feelings, attitudes and mental content. It is the emotional implications of human relationships that are important. The delinquent is distinguished from his non-delinquent sibling by the fact that he has experienced almost always serious dissatisfactions due to inadequate human relationships within the family, the persistence of which means that the checking of a delinquent career already embarked on is no easy matter. Unsatisfying parent-child relationships are a major causal factor in producing delinquent behaviour patterns. When the child is loaded with the physical and mental features which have been described, his pros-

pects of developing and maintaining adequate and emotionally satisfying relationships with at least one or the other of his parents are less than those of his better endowed neighbour.

Probably the most convenient and useful aetiological classification of the mental factors underlying juvenile delinquency is one based on traits of character.

1. *Primary Traits of Character.*

- (i) A *character-trait due to mental deficiency*, either of obvious degree or borderline.
- (ii) A *temperamental character-trait* is an inherent quality of the mental constitution, closely linked to, and often dependent on the physiological endowment of the individual.
- (iii) An *environmental character-trait* is a mental attitude acquired in response to the direct influence of the environment, which comprises everything outside the individual.
- (iv) An *exaggerated character-trait* is due to the over-stimulation of a native tendency; *e.g.* excessive aggressiveness over-developed by parental example.

2. *Secondary Traits of Character.*

- (i) An *organic character-trait* is due directly to organic disease of the central nervous system or endocrine glands, or is a simple reaction to physical abnormality or disease.
- (ii) A *reaction character-trait* is a mental attitude or tendency of mind which serves to repress the opposite tendency; *i.e.* it is a reaction to a difficulty in oneself and not in the environment. For example, a child deprived of love may repress the yearning for love by becoming aggressive and independent, and he must continue thus lest the yearning for love emerges. This is one of the most characteristic varieties of mental abnormality leading to anti-social conduct. It is always accepted by the individual as justified, it is exaggerated and very persistent, and it explains many cases of recidivism. The child rarely has any insight into his condition.

- (iii) A *psychoneurotic character-trait* is the emergence of a repressed tendency. It is always contrary to the character of the individual; *e.g.* the model pupil who periodically becomes a thief.
- (iv) A *psychotic character-trait* is part of a state of mental disorder or insanity.

A common combination of traits of character is that of the temperamental and environmental types. For example, an unusually suggestible type of youth is more prone to join a gang of thieves than is a less suggestible boy.

Treatment depends on the aetiology. For example, primary character-traits may be influenced greatly by punishment and educative measures: reaction character-traits are strengthened by punishment, and only too frequently resist psychotherapy which, together with environmental methods, aims at a healthier way of dealing with the frustrated need and thereby achieving harmony of the whole personality: and psychoneurotic character-traits call for expert psychotherapy which usually effects a radical cure.

REFERENCES

Being on active service, the author is unable to compile a list of references, among which would be included the writings of Wile, Ira S.; Healy, W. and Bronner, A.; Burt, C.; and the Annual Reports of the London County Council for 1930 (Wiley, V.), and 1936-39 (the author).

This work is published with the permission of the Medical Officer of Health, the London County Council, but the Council is in no way responsible for the views expressed which are solely those of the author.

2. THE SOCIAL AND FAMILIAL STUDY OF JUVENILE DELINQUENCY

By DR. E. MILLER

THE nearer we approach the life of the individual, the further away appears the hope or possibility of subjecting behaviour to the laws of science and the methods of the physical and chemical laboratory. The arrangements and movements of matter have for a long time been described and related in Mathematical terms.

Qualities give way to quantities, and even colour differences in organic dyes are reducible to differences of constitution. Where the behaviour of organisms can be viewed in the light of chemistry, there is no obstacle in the way of diagnoses and prognostication based upon scientific principles, but no sooner does one consider the part played by mind and emotions in the precipitation and development of some organic diseases than we enter the realm of the vaguest prediction. At most can we draw up degrees of probability that where such or such an emotional stress is borne by a person, there is a likelihood of this or that organic condition supervening. In short, we can by using large numbers correlate a mental picture with its frequency of occurrence in the history of a given illness.

In fact, that complexity of human nature and the vicissitude of the request kind, sometimes defying description, renders law making little more than the study of probability. Human beings so tend to act along certain lines. One solution has been a common one, our social pressures are shown in common, our institutions, marriage, upbringing and the like have established patterns of conduct conforming with which makes for happiness and average behaviour. But if we were to look into the individual life to discover the why and wherefore of some particular merit or obliquity, we find our law making falling far short of total explanation. The development of psychopathology as a study of the forms of mental disorder and their deep-seated causes has performed a great service, however, in studying the causes of individual variations and in defining some at least of the lines of development common to persons of all cultures. Nay, more, it has shown us particularly through the conjoined studies of psycho-analysis and social anthropology that the forces in the individual and in social aggregations are closely interwoven as woof and warp. Social life as a set of relationships is meaningless in the absence of a study of the persons who comprise it; and vice versa the individuals are meaningless, outside a social setting. Social tension create and mould, individual qualities. Rapport is all in human relations, without it individuals fall apart losing those values which make them human. Even if statistical analysis of a social situation makes it clear that individuals tend to behave in a certain way, it only tells us of their common trends and nothing of their divergences, perhaps even those very divergences which make a finer person compliant and therefore capable of accepting social pressures. For example, the

“good” child who meets school and social requirements may actually be virtuous solely in virtue of the suppression of anti-social trends, and the delinquent child may be delinquent because he has been uprooted from his social milieu, or because his level of intelligence renders him impotent in a class where others are superior.

Clearly, therefore, the factors making for delinquency are manifold. Nevertheless they may be divided into Inborn and Acquired.

1. *Inborn*. Some gene peculiarity producing:

- (a) Mental backwardness and consequent diminished capacity to understand and fulfil social requirements.
- (b) Moral backwardness—associated with normal or even supranormal intelligence, with no accountable reason for aberrant social conduct. (The evidence of Identical Twins.)
- (c) Psychotic character formations.

2. *Acquired*.

- (a) Injuries and infection of the central nervous system producing neurotic changes in character and conduct. e.g. Post Encephalitis, Meningitis, etc.
- (b) Gross environmental anomalies.
 - (i) Delinquent “habits” of a group.
 - (ii) Economic and social degradation.
 - (iii) Change of Mores—evacuation and immigration and failure to adapt.
 - (iv) Educational environment unsuited to certain dullards, “superiors”, and neurotic types.
 - (v) Developmental, psychically-abnormal patterns due to gross disturbances of parent-child relationships.
 - Disturbed sibling relationships.
 - Regression to early infantile reactions with consequent anti-social activities.

In any case studied, any or all of these five processes are at work and can, if statistically studied in sufficiently large samples, be regarded as factors.

In as far as some children who are in delinquent groups remain socially normal, it is reasonable to suppose that this factor alone is not sufficient to constitute a primary cause, although such social pressure as delinquent milieu can prove overwhelming.

So also economic and social degradation do not of themselves account for delinquency—otherwise all economically depressed classes would be asocial. With sufficient pressure so would all persons and indeed biologically speaking it would be abnormal for anyone to refrain from stealing food if hunger was extreme. Economic scruples would be abnormal if a child died rather than steal a loaf.

In the light of psycho-sociological studies, a set of circumstances leading a group to become delinquent in revolt would make delinquency a normal response in that social situation. No views can be established for social crises. For example, can an uprooted evacuee child be regarded as abnormal? Psycho-analytically any child uprooted, with its ethical standards strained, will fall back upon deep psychical conflicts to justify (at least unconsciously) its aberrant social conduct.

In this regard it becomes clear that if we are to understand the emergence of delinquent behaviour we must study it in the light of the knowledge we gather of the social milieus in which it arises. These milieus are, immediate—the family; and mediate, the social environment. The recent development of Field Force Sociology has helped us in the comprehension of the forces involved in human behaviour. According to this method of study made familiar to us by Moreno, Brown and Kurt Lewin, personal behaviour is a function of the social field in which it occurs. A person in order to enter a certain social field must:

1. Conform to the requirements of that field, *i.e.* partake of its character.

2. He must be so compliant within himself as to be free to attain that conformity, *i.e.* he either already possesses some of the characteristics of the field, or is sufficiently resilient to *reconstitute* himself as a member of that field. In fact, if as most modern sociologists hold, there is no Group Mind, or as some psychoanalysts allege that there is no inborn group instinct, individuals do become group minded.

In actual fact this Field Force Psycho-sociology was anticipated in the Child Guidance Movement when the complexity of each problem compelled the psychiatrist to add to his team a social worker in addition to the educational psychologist who measured

on accepted statistical standards the child's intelligence and abilities. Psycho-analysis had explored the field of interior forces which produced the character peculiarities and neurotic reactions which operated largely privately. But it became increasingly clear that even the internal forces were not without their cultural features. The Oedipus Complex, for example, unconscious in origin, could not arise unless the parent-child relationships had been created by the tensions between the elements in the family regarded as itself a socio-psychological field. Indeed, Freud had speculated that even this complex which determined so much in conduct as to be regarded as a nucleus to emotional development, was itself a product of a neurotic social situation in paleolithic times when the hoard family came into existence.

We cannot trace the means whereby this early social crisis in the life of primitive man precipitated a psychological process which Freud regarded as fundamental to all social conduct. But it is clear that even on this assumption interpersonal relationships work in a field which sets up tension between persons; these tensions are resolved in conduct which is either compliant or rebellious. The social worker together with the psychiatrist and the educational psychologists came early into the work to explore the forces in the family and social field which helped to explain the abnormal conduct of children, and thus to suggest remedies.

Poverty, overcrowding, and family disruption, are undoubtedly factors in the production of crime; but we are forced to account for those criminal tendencies which are so frequently found unassociated with any one or other of these three. I had occasion in the last few years to study a fair sample of young delinquents, and I have been led to the conclusion that while the environmental factors, the social factors, play a part in opening the road as it were, to delinquency, there is some personal factor or factors which impel this child rather than that to pursue this path. Interesting sidelights on this phenomenon have come to me from the study of the co-called "delinquent gang", and I am at present engaged upon investigation of the forces that make for gang formation. Interest in this has been aroused not merely to study the psychology of this form of aggregation but to discover whether it has a truly social quality. Is the gang really a social aggregate, or is it the gravitation of youths with fleeting common interests? I have in mind two gangs of juvenile delinquents, the members of which were engaged upon, or were alleged to have been engaged upon a

series of minor offences occurring spasmodically over a period of about two years. The ages of both these gangs ranged from 7 to 14; the intelligence of their members was also very wide in range. In one gang of seven, the Intelligence Quotient ranged from a lowest grade of 80 to a highest grade of 120. There was also a difference, not very great, but an appreciable difference in social level. One or two came from superior artisan homes; one or two from indifferent homes, and the rest from homes on the border of destitution. When the history of their behaviour was investigated, it was found that this aggregate fell apart from time to time, rejoined, would occasionally attract a new member for a time, drop him and take on another. I could discover no sense of community between them, no feeling of a common end dominating or animating the group as such, and little sense of the honour of the group. What held them together, on close examination, was the fact that each one of them needed some form of psychological outlet which could only be found through the temporary aggregation. Furthermore, it was discovered that there was always in both groups at some time or another a "master-mind" who would either from time to time take command of operations, or would instigate the others to carry out these operations. It was usually found that the cause of their being caught by the police was due to the indiscretion or slowness of its most unintelligent member. Strange though it may seem, quite the larger number of the young delinquents with whom I have had to deal have been of good character in the home, if less so at school. This does not mean that such individual children have come from good homes, but that the parents have been frankly unable to see any defects in the child's home behaviour, or they have themselves been indifferent to the behaviour of their children.

Some of the most startling cases of juvenile delinquency that I have investigated amongst the moderately poor, have sprung from satisfactory homes; that is to say, homes in which there has been no overt disorders or disruptions. Let me quote an interesting case before concluding, to show the contrast between a home of a very doubtful character which produced a stable boy, and a home of perfect stability regarded externally, or as an environment, which produced a boy who not only stole but was guilty of a number of perversions.

In the first case, the lad was brought to my notice because he was said to be in danger of corruption. He was brought up by blind

parents who were the directors of a blind community having a subtle organisation of its own, its own sexual morality, its own convivialities, and its own designed hostility towards the police. The boy in question had a superior intelligence; he had refused to leave what is regarded as a poisonous environment; he daily witnessed the strange submerged life of this blind beggar community, yet he had succeeded in this environment in winning a scholarship to a secondary school, and had all the qualities of a normal boy.

The other lad lives in a stable environment, but yet he harbours feelings of hostility towards his parents, has strange ideas of guilt and hell, and believes that the Devil impels him to perform the delinquencies and perversions for which he was referred to me. He is a boy of superior intelligence with excellent powers of expression, yet is so guilt ridden that he is obliged from time to time to break out in a variety of behaviour disorders.

To what extent can delinquent behaviour be regarded as a social phenomena? And to what extent can we separate the moral judgment on crime from the legal or social judgment? In the case of the boy I have just quoted, two concepts come before us for consideration; crime and guilt. Modern psychology has shown from deep analysis of the mind that the sense of guilt is a nodal point in the production of neurosis. Every mental conflict which lies at the root of neurotic disorder is an expression of a moral conflict, and however unconscious this conflict may be, the sense of guilt is always to be found there. A crime, on the other hand, although most frequently immoral in character, is not necessarily sinful, using this term in relation to individual psychology. But one feels that the very emergence in society of the concept of crime has been made possible only because in individual psychology this sense of guilt exists. I do not suggest for one moment that there are not purely social misdemeanours, but that the law makes them so for psychological reasons inherent in human development. It is very difficult to determine at what point an aberration of behaviour should become subject to social censorship. Times change and the social attitude towards crimes changes also. There is a curious time lag about the recognition of some anti-social acts, and this time lag one feels is due to social rather than to psychological factors, but strangely enough, even in our courts of law, there is a tendency to use moral judgments in the assessment of purely anti-social acts. Lawyers rightly say that they have nothing to do with morals and that their duty lies entirely in considering

anti-social acts in terms of the law. Sidgwick says in his *Methods of Ethics*, "that punishment should be merely deterrent is I think too purely utilitarian for current opinion. That opinion seems still to incline to the view that a man who has done wrong ought to suffer pain in return even if no benefit result to him or to others from the pain". I believe that Sidgwick has expressed a very sound view, but my grounds for regarding it as sound are based upon psychological rather than ethical reasoning. I think that we all, not only in our social capacity, but as individuals, are ruled by deep moral judgments psychological in origin, and whether we be judging social acts or private acts, whether we be considering neurotic guilt or the guilt of delinquency, as overt behaviour, we are still judging, whether we know it or not, on the basis of our own unconscious psychological motivations.

Let us take a simple example. B.J., a boy of 12, lived with his family—parents and a brother and sister in a stable suburb (X) of London. He had an intelligence of 110 (I.Q.) and was happy and compliant. The father's work necessitated his moving into another area (Y)—near a gas works by a canal side. Owing to housing restrictions the family settled in a not too salubrious street, and the boy joined a local school where the intelligence level was low. Within 3 months the boy was charged at the Children's Court for larceny and damage of property. He had become the head of a gang of delinquent boys between the ages of 9 and 14, who were charged with him. Delinquency, so the social worker found, was prevalent in the locality Y. The street in which the family lived was a canal side row of dwellings of some 65 houses. An ecological survey showed that here there were living five prostitutes and ten receivers of stolen property. 25 children were of low intelligence, 6 attending special schools had intelligence quotients of 65 per cent. There had been many convictions for stealing, drunkenness, etc., amongst the adults. B.J.'s intelligence was above that of every member of his loosely knit gang. It is evident that he was able with this advantage to make himself felt in the environment which was "normally asocial" compared with other localities. He needed to become normal in his new surroundings where delinquency was the rule rather than the exception. Why did his brother and sister not fall victims? They were children of average ability but much younger, *i.e.* 6 and 8. He had been an only child for 4 years, and resented their birth at a time when the father was relatively well adjusted economically. The additional

children and some economic deterioration had placed an added burden on the family exchequer, during a period of slump in the father's trade. Here we are presented with an interesting and characteristic social-psychological problem, working out in three fields of psychological tension born of two forms of interpersonal relationship :—

1. The intra-psychical field—a temperamentally active, sanguine and intelligent boy, forthcoming and dominating.

2. A family field—the intelligent dominating boy resenting the intrusion of the brother and sister to whom he (wrongly) attributes the diminution in family comforts and satisfactions. He develops resentment of family authority and dislike of the siblings who share or rather dispose him of the monopoly of parental affection.

3. A social field—the pressure of which is all in favour of the throwing over of authoritarian ties. He now finds that to keep his “end up” he must conform to the mores of the new group. His added intelligence gives him opportunity to dominate—he finds “siblings” who accept his authority. In place of being neglected in the family field he can now become a centre of social tension in which he can assert the maximum force.

His frustration at home is now diminished by the satisfaction he receives in this order → operation of his intelligence as gang leader → satisfaction of dominating personality traits → reduction of tension of the family conflict → Delinquency appears to be normal in the new group and therefore does not give rise to any clearly apprehended moral guilt.

This example makes clear the typical processes in a case of juvenile delinquency and brings into relief the nodal points in the present day methods of enquiry. But we have in each case to consider the relative weights of each of the outstanding factors, and above all we must be particularly careful to see that we do not become the slaves of words and of terms. For example, it is of paramount importance to be precise or as precise as knowledge permits, as to the meaning of such terms as *heredity* and *social*. As regards the first term we must guard against the danger of regarding certain traits and qualities as unitary in character; and furthermore as to whether we are dealing in truth with qualities which are hereditary or the products of psychological development. Parents who bring erring children to clinics are prone to attribute traits and qualities to the reappearance of preparental and parental peculiarities. “He gets his bad temper from his

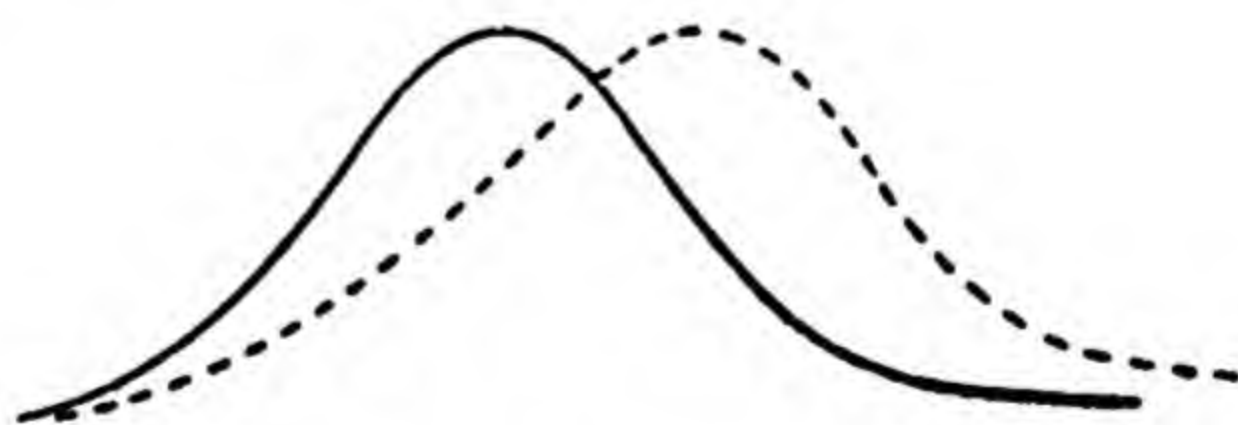
father." "Uncle George was arrested for stealing." "Aunt Sally 'went gay' and that is coming out in our Lucy who won't keep home at night." We do not yet know how the genes behave, whether integrally or in virtue of their relationship one to another. In fact, the heredity studies of delinquency are singularly barren of illumination. Moreover, it is very difficult to obtain reliable family histories from social groups notoriously prone to exaggerate and to suppress facts about relatives.

With regard to the hereditary factors of Delinquency, two important lines of enquiry have been followed. One by Goddard in his researches on Intelligence and Crime, and the other by Lange on the study of delinquency in identical terms. Goddard holds from the study of a series of age groups and locality groups, that low grade intelligence is a factor in delinquency. Most observers will agree with him that intelligence and criminal behaviour correlate one with another, but where Goddard places most delinquents in the low grade group, other observers hold that most delinquents are found in the group with intelligence quotients between 60 and 80. These studies are from the observation of juvenile delinquents charged in Children's Courts, and not from the older groups, post adolescent and adults. It may well be that when Goddard carried out his enquiries the Mental Tests used did not clearly differentiate intelligence grades amongst adults who are very difficult to assess by the standard Binet Simon types of test. To-day both Performance Tests and Verbal Tests are much more discriminating for the higher age groups. It has been noted, particularly in the use of the Penrose Raven Matrix Test (Visual Perception), that intelligence scores tend to fall off with increasing age. The maximum age for the full capacities of intelligence to be exhibited is in the 18 to 25 group. Very bright persons over 30 may fail to achieve a full score. Why this is so there is no place here to discuss. This phenomenon is only brought forward to stress the fact that the Goddard view of low intelligence is a function of this fact and these tests difficulties.

Now intelligence is a function of neither nurture nor of education. Researches have proved to the satisfaction of psychological statisticians that Intelligence is an inborn function of the mind, and the Intelligence quotient follows a person unalterably through his or her life. Disease, profound mental conflict may lead to deterioration, but this factor can be elucidated by other test enquiries.

Mental backwardness, being inborn, will render certain persons from an early age less accessible to educative, moral and social influences. The Mores of the group are not easily acquired, or if acquired are more easily abandoned; responsibility and obligation are not clearly apprehended; in fact, capacity to conform and to comply is reduced. In the moderate grade defective or feeble-minded, the mind is sufficiently capable of sensing the world to get something out of it; in fact, to see egoistically the profits of a delinquent career but not sufficient to introspect on the possibility of losses to follow from delinquency. Lack of adequate intelligence does not produce delinquency, it merely releases from rational restraint the deeper urges that lie at the root of asocial conduct.

It has been said that delinquency goes with the possession or the lack of certain intellectual qualities or abilities. For example, some are of a literary bent, are voracious readers and live in phantasy. These do well in mental tests. Other types show considerable manual dexterity and mechanical aptitude. Although no refined researches have substantiated the existence of two clearly defined groups, there are no doubt indications that amongst the intellectually superior delinquents, there are some who do well in non verbal performance tests and tests of mechanical aptitude, while another group do poorly at these tests, yet very well, sometimes brilliantly at verbal tests. A group of young adults seen by the writer were found on the whole (some 300 cases) to score equally on both types of test, but plotting of these achievements produced a bimodal curve if the two groups of tests were plotted separately and superimposed.



If this bimodal distribution is true of a group of normal young adults, then the presence of two groups amongst delinquents has little special significance unless it be proved that in delinquents polarity is very obvious. This has not been proved.

Hersch alleges, however, that most juvenile delinquents have good mechanical aptitudes, and frustration of this ability in routine education, produces tensions and frictions that produce anti-social conduct.

There is no evidence in this observer's work that a normal control group was used as comparison.

Most observers agree that while intelligence is a factor in the retention of normal standards of social behaviour, it alone does not occasion delinquency. It is, however, a soil from which the seeds of deep psychological emotional disturbance can take root, sprout, and perhaps flourish. Here again, to pursue the analogy the atmosphere allows for the incubation of the seed as well as the soil; the encouragement afforded by a bad social atmosphere will play a significant part in fructifying a trend which has taken root in a poor intellectual soil.

3. THE PROBLEM OF BIRTH-ORDER AND DELINQUENCY

By DR. E. MILLER

MANY lines of enquiry have been traced for the discovery of the distribution of delinquency.

Amongst the many of such investigations the distribution in families of delinquent members has aroused as much interest as the incidence of neurotic and psychotic disorders. From the point of view of psychopathology the stresses of family life and the deep conflicts set up in the mind as a result of disturbed relations between parent and child have been rightly regarded as causes of aberrant conduct. But the question that is frequently prompted is this: Why do members of families differ so widely seeing that they are each subject to the same parents?

While according to Fortes it is admitted the position in the family alters a child's relationship to parents, the conflicts set up are relatively superficial and cannot be regarded as alone responsible for significant differences in neurotic control and social behaviour. Are the factors a constellation of genetic and environmental forces? The study of birth order and psychological characters has engaged the minds of many investigators. The importance of such a study has been emphasised by Hogben who points how they can contribute towards an understanding of the relation between heredity and environment in the moulding of social behaviour. He shows that when we find a particular birth position unfavourable from the point of view of some aspect of social be-

haviour, it may be inferred that environmental agencies—which include such factors as prenatal and labour difficulties of the mother—are responsible for this, and consequently have a powerful influence on the aspect of social behaviour under consideration.

Both the writer and a former colleague, Dr. Fortes, have made a survey of the literature in this field which is germane to the study of those deviations in social behaviour designated as *crime* and *delinquency* in children.

GENERAL CONSIDERATIONS

Several excellent summaries of the results of research in special departments of the field are available, so that it would be superfluous to traverse the whole of the literature. Among critical summaries, the best are those of Holmes, Hsiao, Thurstone and Jenkins, and Jones, the last dealing particularly with the relationship between birth order and intelligence. Karl Pearson's well-known work is of great importance, both as summarising the contributions made in his laboratory to this study, and in regard to the statistical methods applicable in this branch of research. For our purpose it will be sufficient to deal briefly with the investigations immediately germane to our problem. As a preliminary, it is necessary to consider what constitutes delinquency.

Healy and Burt, in their classical works on juvenile delinquency, have taught us that delinquency is by no means a unitary, homogeneous mode of human behaviour. Every delinquent act may have behind it any or all of several physical, psychological, and social variables, singly or in combination. Actual physical disease is not of great importance in the causation of delinquency, we are told. Malnutrition, retardation or acceleration of physical growth and development, bad physical habits, etc., are much more prominent. But mental conditions greatly outweigh the physical conditions in delinquency. Of these, intelligence seems to be the most important single factor. Up to 80 per cent. of delinquents appear to be intellectually retarded. Retardation in educational attainments appears to be another potent factor. Above all, these and other writers lay great stress upon the emotional, motivational, and temperamental background of delinquency, both in their normal and in their abnormal forms. And it seems to be not so much a matter of the operation of a specific emotion at a given time, but of the general emotional and temperamental organisa-

tion of the individual delinquent. It is a problem of characterology, as Healy calls it. Furthermore, a great many highly variable environmental conditions appear to be involved as well—poverty, vicious homes, defective family relationships, bad companions and so on. Each and all of these numerous variables which go to make up the texture of the delinquent's personality and constitute the basis of his misdemeanours, may be correlated with fraternal position. Even the environmental variables, as Dr. Weill has shown, may fall with different severity upon different members of a sibship. Hence, if any correlation between juvenile delinquency and birth order or fraternal position exists, it may be due, at bottom, to the effect of one or some of these variables. It behoves us therefore to enquire what correlations exist between these variables and position in sibship. To be sure, we are perhaps to-day little better off for conclusive evidence than Holmes was in 1921, when he wrote "Our information on [these] subjects is in a most unsatisfactory state." Such investigations are indeed beset with many difficulties, as Jones, Hsiao, and Holmes have pointed out. We need not enumerate them here. Those which may be relevant to our problem will be dealt with at a later stage.

PHYSICAL CHARACTERISTICS

The investigation of physical traits and abnormalities has received a great deal of attention in the present connection, though controversy still rages about them. Pearson and his co-workers have contributed prolifically in this province, particularly on the question of the relation of birth order to diseased and pathological conditions. The pathological conditions they have studied range from albinism and cataract on the one hand to tuberculosis and epilepsy on the other. Like many workers in this field, they do not always make it clear whether they are dealing with pregnancy order—including still-births and miscarriages in the counting; or birth order—including only all children born alive; or fraternal position in the sibship surviving at a given time. Their general conclusion is that oldest and youngest children are most liable to disease conditions—oldest especially so—and middle children least so. These conclusions have not by any means received general acceptance. Considerable dispute has centred round the possible effect of factors like modal age of onset, in *e.g.* tuberculosis, and small families in stocks of low fertility.

Of more interest for our particular problem are the studies which have been made of differential mortality in relation to birth order. It seems well established that still-births occur more frequently among first than among subsequently born children. One consequence is that, as Hsiao found, about 15 per cent. of children designated first or second born are actually second or third born. There is also a considerable amount of evidence to show that first born children have a higher infant mortality than subsequent children, as far as about the fifth or sixth child. Some writers assert that this initial handicap of the first born is compensated by greater longevity of surviving first borns, so that the proportions of survivors among the different birth orders become equalised in later life. This conclusion has, however, not escaped dispute. At any rate, some correlation seems to exist between birth order and selective mortality, though its exact nature is not definitely known. (Literature summarised in Hsiao, *op. cit.*, Thurstone and Jenkins, *op. cit.*)

PSYCHOLOGICAL CHARACTERISTICS

Among the psychological variables of interest to us, Intelligence has received most attention, in the present connection. The pioneer studies of Galton, Ellis and Cattell were concerned with the birth order distribution of intellectually eminent men. Their general conclusion was that first born children have a greater chance of being intellectually eminent than later children, with youngest children occupying the next most advantageous position (Ellis). Terman, working with intelligence tests, obtained analogous results for gifted children, but advances them with reservations.

At the other end of the scale, a number of studies have dealt with the incidence of mental defect, both mild and extreme, in the sibship. Of extreme forms of defect, Mongolism has been definitely shown to occur most frequently among late and last born children. Imbecility, on the other hand, has been held by Pearson to occur most often among first born. Dayton's recent study based on intelligence tests for more than 10,000 retarded school children, refers to the milder forms of defect. He maintains that the highest incidence of mental defect is to be found among intermediate children. In the later paper, however, he gives calculations showing that the average number of children born to a native mother

before and including the birth of a marked child is greater than the average number of children of native mothers of the same age in New York State, while the opposite holds for foreign born mothers. This suggests that among native families retardates tend to occur later and in larger families than children of mothers of the same age in the general population; and that among foreign families retardates tend to occur earlier and in smaller families—possibly due to social selection. It may be that these two tendencies cancel each other in his general results. Thurstone and Jenkins have observed that in Dayton's data the ratio of defectives to retardates (I.Q. 70 and under to I.Q. over 70) is greatest for first borns, and conclude from this that the first born are inferior. Jones, however, attributes this result to scale inequalities in the tests.

Where investigators have worked with expectancy tables, like Dayton, interpretation of the results has been hampered by the well established finding that intelligence correlates negatively with size of family (Sutherland and Thomson, Chapman and Wiggins, Lentz and Argelander, among others; but Thurstone and Jenkins report the reverse for low grade mental defectives). To avoid this difficulty, several investigators have worked with pairs or trios of siblings. Arthur, using this method, concluded that later children were progressively more intelligent than first borns, judged by intelligence tests; but her results have been criticised on the score that they make no correction for scale inequalities, and are exposed to serious sampling errors (Jones). Thurstone and Jenkins, using much more elaborate statistical safeguards, compared the test scores of various combinations of siblings pair sent to the Institute for Juvenile Research at Chicago. They conclude that "There appears to be a definite tendency for the intelligence quotient to increase progressively, within sibships, from the first born to the later birth numbers . . . past the seventh born child". They cite in support an unpublished research of Miss Steckel on about 6,000 sibling pairs. Jones and Hsiao, however, both in their joint work and separately, have published data contradicting these findings. In particular, Hsiao's very careful work seems to bear out Jones' criticism that the handicap of the first born is only apparent, and is due to the fact that first born are always older than later siblings when tested, and to the fact that inequalities in scale construction penalise older subjects. When due corrections are made the advantage of the later born vanishes.

We must conclude with Jones that no correlation between birth order and intelligence has been definitely established, except in the extreme pathological case of Mongolism.

CHARACTER AND PERSONALITY TRAITS

Still less capable of claiming any finality are the studies dealing with the relation between birth order and emotional, temperamental, or personality traits. The dogmatic statements made by many eminent clinical psychologists and psychiatrists generally rely for support upon case studies only, and these often shaped from the outset to fit the particular theory sponsored by the interpreter. Careful statistics are never offered in confirmation of these theories. Among earlier exponents of this approach Stanley Hall is remembered for his dictum "being an only child is a disease in itself". In its most radical form this approach is to-day represented by Alfred Adler's school of Individual Psychology. Adler's own writings teem with statements about the distinctive character traits of oldest children, youngest children, only children, etc. Among his disciples, Wexberg and Wolfe have given resumés of the "type relations" which characterise different fraternal positions. The oldest child, we are told, places a high valuation on power, and will go to any lengths to retain it; second children are "energetic, kinetic", competitive persons, youngest sons either achieve high positions, or if they lack courage, descend to the lowest dregs, the neurotics and ne'er-do-weels; the only child is "particularly prone to the neurotic ideal of Godlikeness, and falls a victim to conflict and maladjustment. Homburger gives a grim list of the personality defects of only children.

Some attempts have been made to check assertions of this and the like sort by experiment. Bohannon's questionnaire enquiry, which led him to ascribe all sorts of serious handicaps to only children, is not convincing because of the absence of statistical safeguards. More recently Fenton has compared only, oldest, youngest, and intermediate children on the basis of character ratings by teachers and scores on the Woodworth questionnaire. He concludes that among school children only children are neither inferior nor superior to other children in a number of character traits. At the most they may be slightly over-confident, and may have somewhat more severe, though fewer, nervous symptoms than other children. His results with College students were incon-

clusive. Homburger cites Neter and Friedjung as finding only children to be more neuropathic than others.

Using a rating technique similar to Fenton's, Goodenough and Leahy have published what is probably the best study of the kind. Their subjects were 300 kindergarten children falling into the four groups, oldest, middle, youngest, and only children. Their statistical checks are as careful as the material permits. They find that oldest children tend to receive extreme ratings more frequently than any of the other groups, while youngest children receive fewest extreme ratings. Oldest children appear to lack aggressiveness, self-confidence, and leadership, and to be more inclined to introversion than any of the other groups. Only children, on the other hand, seem to be aggressive, self-confident, and flighty. Youngest children come out best of all. The authors suggest three possible reasons for the shortcomings of oldest children; the comparative inexperience of parents at the birth of the first child, the strain placed upon oldest children who have responsibilities such as the care of younger siblings, and the difficulties of adjustment consequent upon the change from only child to oldest child. In another part of the same paper they present figures showing the birth order incidence of 322 cases referred to a Child Guidance Clinic. Oldest children were found to have the highest incidence. In this sample there were indications that stealing and sex misconduct occurred most frequently with middle children, especially with girls, whereas nervousness, temper tantrums, and such-like problems occurred mostly among only children. Too much stress cannot be laid upon these findings, since no correction is made for size of family, age, or social status. The writers conclude that their investigation "warrants the conclusion that the disproportionate number of oldest children found among delinquents is not wholly an artifact of selection, but is based upon real differences of personality". They are here perhaps pressing their results too far, not only for the reason that, as Jones points out, uncontrolled sampling effects may be intruding, but also because character ratings are notoriously unreliable.

One other character study, though it is technically less well founded than that of Goodenough and Leahy, deserves comment, that of Busemann.

In his series of enquiries, Busemann makes use of scholastic achievement, marks given by teachers for character traits like industriousness, obedience, deportment, etc., and self-ratings by the

children. His subjects were school children mainly of middle or artisan class parentage. His most general finding is that children from medium sized families outstrip both children from small families and children from large families in scholastic achievement and character qualities. First children have the best record, especially in medium-sized families, youngest children the worst record. From the self-ratings he concludes that only children and children from either extreme of family size are most dissatisfied with themselves, and most introverted. Only children also appear to be the most restless and (boys) the least amenable to discipline (Goodenough and Leahy make a similar observation). He also investigated the effects of the sexual configuration of the sibship, and found that the more siblings of the opposite sex a child had the worse was its record. (The matter cannot, however, be quite so simple. Thurstone and Jenkins found that among families with more than one child among the Institute cases, it was significantly less advantageous for behaviour adjustment if the next oldest or next youngest sibling of the patient was of the same sex.) Natal. interval, too, according to Busemann's results, may have a differential effect. In two child families, for example, he found the older children to have a better record the smaller the interval between the siblings.

Busemann's research is rich in suggestive findings, but suffers from an inadequacy of statistical controls. He himself hints at one possible factor of social selection. He drew his population from fee-paying schools. Well-to-do parents could afford to send their children to such schools even if they showed no aptitude for school, and even if the families were large. On the other hand, poorer parents could only afford to do so if their families were small, and would probably only make the effort in the case of able children. This might well have produced an artificial selection of able children in small families.

BEHAVIOUR DISORDERS

Besides this direct mode of attack on the question of a relationship between birth order and emotional conditions, indirect methods have been utilised as well. As with intelligence the possibility of such a correlation for extreme forms of emotional aberration has received considerable attention. Heron, one of Pearson's student's, found that first born predominated in an asylum popu-

lation of insane. More recently Schuler in a careful study of 1224 cases of insanity, has rejected Heron's conclusion. He draws attention to the disturbed sex ratio of institutional cases, and to the sex differences in diagnoses, which lead to the weighting of certain diagnoses by a sex factor. He criticises Pearson's "short table" method for counting only children as first children. In two child families he finds the elder position to be significantly weighted, especially in paranoid dementia praecox. He finds no discrepancy between expected and observed frequencies of first borns, and a slight excess of intermediates, in sibships of three to seven members; and a slight excess of children in extreme positions in sibships larger than seven.

Schuler's work makes it clear that if there is any correlation between birth order and insanity it is not so simple as Heron and Pearson would have it. As Jones points out, studies of insanity based on institution records are liable to many errors. There is the fact that the term "insanity" covers many conditions, with different modal ages of onset, and as Schuler shows, different sexual incidence. Each psychosis may have its peculiar relationship with birth order. Then there is the question of the abnormal sex ratio; and finally, the question of incomplete families, due in part to the institutional segregation of some parents of the insane.

Cases referred to Child Guidance Clinics on account of behaviour disorders have been investigated in this connection as well. Here, too, the heterogeneous behaviour anomalies grouped together, the incompleteness of families, age factors, and social factors, create difficulties. We have already cited Goodenough and Leahy's study of a clinic population. Thurstone and Jenkins selected cases between the ages of 17 and 21 years from completed families, appearing in their Institute population. They found an excess of first borns in the ensuing sample of 101 cases, Rosenow reports similar findings, but attributes the result largely to an age factor, which operates in favour of the first born in small sibships, especially sibships of two, and in the opposite direction in large sibships. Levy, using the birth order distribution of all sibships in Chicago (calculated from Census data on certain assumptions which may not be beyond query) as a control upon his problem child population, also concludes that the first born are weighted above expectation, and next to them, the third born. His data allow him to neglect age as factor, since the mean age of every birth order was about $11\frac{1}{2}$ years, but not the possibility of a dis-

turbing sex ratio, which in his data was two to one. He finds that two child families produce most emotional and personality problems—in agreement with Schuler and Rosenow; and that only children are the most delinquent and have most scholastic difficulties.

Dr. B. Weill's study also deals with cases referred for child guidance, but from a clinical rather than a statistical point of view. The value of her study lies not in what it proves or disproves, but in demonstrating the extreme complexity of the family constellation as a dynamic influence in the development of social behaviour. Her thesis is that every child has his or her own family "environment" even within one and the same family; and her case studies lend much cogency to her contention. This need not, however, preclude the possibility that, *e.g.* all first children have something common to their respective environments, be it only the fact of "firstness", which may conduce to certain forms of social behaviour rather than others. Oberndorf propounds a similar view from the psycho-analytic standpoint.

CRIME AND DELINQUENCY

Finally we come to studies directly concerned with crime and delinquency as deviations from the norms of social behaviour. Goring, in his classical study of the adult criminal, devoted a chapter to the consideration of the birth order distribution of criminals. He found a large excess of first and second borns. He seems inclined to attribute this partly to the excessive mortality of later children among the social strata from which criminals are recruited, and partly to constitutional factors analogous to those responsible for the selection of first born among the tuberculous and the insane. Pearson, reconsidering Goring's data, reaches the same conclusion, but appears to lay more stress upon the constitutional determinants.

There are no studies of juvenile delinquents to compare with this one for statistical thoroughness. Burt reports an excessive tendency for only children to become delinquents; but he counts as only children all those growing up more or less without siblings nearby in age, irrespective of their true birth position. Slawson, working with about 1,500 delinquent boys, found that 4½ per cent. were only children, as compared with 7 per cent. only children among employed boys of similar age and social status. Levy, it will be remembered, found that only children are most prone to

delinquency, but Blatz and Bott report the opposite among school children. Breckinridge and Abbott found an excess of oldest children among 584 delinquent boys, as compared with youngest and only children. Baker, Decker and Hill, on the other hand, report no correlation between birth order and stealing in boys. Their sample was very small, however. Healy gives figures showing that about 12 per cent. of his delinquents were only children. This seems a considerable proportion, and is equal to that reported by Burt for socially only children, though Healy himself lays no stress upon it. A few other studies making direct or indirect reference to the incidence of delinquents in different birth positions have come to our notice; but they appear to be so lacking in statistical or other precautions that they may be neglected.

On the whole, therefore, in regard to the relation between birth order and juvenile crime we have singularly poor and contradictory information. The various factors which may affect an observed birth order distribution of a selected population—age, incomplete families, social status, etc.—have received little or no attention in the studies of young delinquents.

To sum up, then, which of the variables involved in juvenile delinquency has any correlation with birth order? The consensus of evidence is equivocal in regard to all of them. If it is a fact that the infant mortality of first born is highest of all, this will affect the population as a whole and thus not give a particular bias to our sample. On the other hand, the relative intellectual handicap attributed to first born children by some writers, if it were proven, would be of great importance to us. An observed excess of first children among delinquents might then be merely a consequence of the relative backwardness of first children—we know that delinquents are in the aggregate retarded in intelligence (Burt, Slawson). But the evidence in opposition to this view is as strong as that in favour of it. The same argument applies to the evidence in regard to specific emotional, temperamental, or personality traits, which is, indeed, even less satisfactory because of the difficulty of measuring such traits. When it is taken in conjunction with the evidence referring to aberrant social behaviour, such as insanity, childhood behaviour disorders, and crime, there is a suggestion that first children are more prone to deviate from the average than others, in traits involved in aberrant social behaviour.

LIST OF REFERENCES

- ADLER, A. *Understanding Human Nature*. 1928.
- ANSELL, C. "Statistics of families in the upper and professional classes." *Nat. Life Assur. Soc.* 1874.
- ARGELANDER, A. "Das wirtschaftliche Milieu in seiner Auswirkung auf Schulleistung and Intelligenzalter des Kindes." *Zsch. f. Kinderforsch.* 1931, XXXVIII, 4, 589.
- ARTHUR, G. "The relation of I.Q. to position in family." *J. Educ. Psychol.* 1926, XVII, 541-550.
- BAKER, H. J., DECKER, F. J., and HILL, A. S. "A study of juvenile theft." *Jnl. Educ. Res.* 1929, XXX, 81
- BLATZ, W. E., and BOTT, H. "Studies in mental hygiene, I. Behaviour of public school children—a description of method." *Jnl. Genet. Psychol.* 1927, XXXIV, 552.
- BOHANNON, E. W. "The only child in a family." *Pedag. Semin.* 1898, V, 475 ff.
- BRECKINRIDGE, S. P., and ABBOTT, E. *The Delinquent Child and the Home*. 1912.
- BURT, C. *The Young Delinquent*. 2nd edn. 1927.
- BUSEMANN, A. "Geschwisterschaft, Schultüchtigkeit, und Charakter." *Zsch. f. Kinderforsch.* 1928, XXXIV, 1. "Geschwisterschaft und Schulzensuren." *Ibid.* 1928, XXXIV, 522; 1929, XXXV, 1; 1929, XXXV, 509.
- CATTELL, J. MCK. *American Men of Science*.
- CHAPMAN, J. C., and WIGGINS, D. M. "Relation of family size to intelligence of offspring and socio-economic status of family." *Pedag. Semin.* 1925, XXXIII, 414 ff.
- DAYTON, N. A. "Intelligence and size of family." *Jnl. Hered.* 1929, XX, 219 ff, and 365 ff.
- ELLIS, H. *A Study of British Genius*. 1904.
- FENTON, N. "The only child." *Jnl. Genet. Psychol.* 1928, XXXV, 546 ff.
- GALTON, F. *English Men of Science, their Nature and Nurture*. London, 1874.
- GOODENOUGH, F. L., and LEAHY, A. M. "The effect of certain family relationships upon the development of personality." *Pedag. Semin.* 1927, XXXIV, 45 ff.
- GORING, C. *The English Convict*. H.M. Stationary Office, London. (Abridged edition, 1919.)
- GRIMBERG, L. *Emotion and Delinquency*. 1928.
- HEALY, W. *Mental Conflict and Misconduct*. 1919.
- HEALY, W. *The Individual Delinquent*. 1915.

- HERON, D. "A first study of the statistics of insanity and the inheritance of the insane diathesis." *Francis Galton Eugen, Lab. Mem.* II. 1907.
- HOGBEN, L. T. *Genetic Principles in Medicine and Social Science.* 1931.
- HOLMES, S. J. *The Trend of the Race.* 1921.
to Intelligence." *Genetic Psychol. Monog.* 1931, IX, 1-118.
- HOMBURGER, A. *Psychopathologie des Kindesalters.* 1926.
- HSIAO, H. H. "The Status of the First Born, with special Reference to Intelligence." *Genetic Psychol. Monog.* 1931, IX, 1-118.
- JONES, H. E. "Order of birth in relation to the development of the Child." In C. Murchison (edit.) *A Handbook of Child Psychology.* 1931.
- JONES, H. E., and HSIAO, H. H. "A preliminary study of intelligence as a function of birth order." *Jnl. Genet. Psychol.* 1928, XXXV, 428.
- LENTZ, T. "Relation of I.Q. to size of family." *Jnl. Educ. Psychol.* 1927, XVIII, 486 ff.
- LEVY, J. "A quantitative study of behaviour problems in relation to family constellation." *Amer. Jnl. Psychiat. (N.S.)* 1931, X, 637.
- OBERNDORF, C. P. "Psycho-analysis of siblings." *Amer. Jnl. Psychiat. (N.S.)* 1929, VIII, 1007.
- PEARSON, KARL. "On the handicapping of the first born." *Eugenics, Lab. Lecture Series.* 1914, X.
- ROSENOW, C. "The incidence of first born among problem children." *Jnl. Genet. Psychol.* 1930, XXXVII, 145.
- SCHULER, E. A. "The relationship of birth order and fraternal position to incidence of insanity." *Amer. Jnl. Sociol.* 1930, XXVI, 28.
- SLAWSON, J. *The Delinquent Boy: A socio-psychological study.* 1926.
- SUTHERLAND, H. E. G., and THOMSON, G. H. "The correlation between intelligence and size of family." *Brit. Jnl. Psychol.* 1926, XVII, 81 ff.
- TERMAN, L. M. "The Mental and Physical Traits of a Thousand Gifted Children." *Genetic Studies of Genius*, Vol. I. 1925.
- THURSTONE, L. L., and JENKINS, P. L. "Order of Birth, Parent Age, and Intelligence." *Behaviour Res. Fund. Monog.* Chicago. 1931.
- THURSTONE, L. L., and JENKINS, P. L. "Birth Order and intelligence." *Jnl. Educ. Psychol.* 1929, XX, 641.
- WEILL, B. C. "The Behaviour of Young Children of the same Family." *Harvard Stud. Educn.*, Vol. 10, 1928.
- WEXBERG, E. *Individual Psychology.* 1930.
- WOLFE, H. B. "The philosophy of Individual Psychology." *Int. Zsch. f. Ind. Psych.* April, 1927, 112.

XI

REACTION TO MILITARY LIFE AND CRIMINAL BEHAVIOUR

By DR. G. DE M. RUDOLF

CRIME in the Army includes behaviour which is not considered criminal in civil life. The man who arrives late, dirty or unshaven for work, or who does not keep his belongings neat, does not commit a crime in civil life, but a man who is late for parade, is unshaven or careless over his belongings is "crimed" in the Army. To keep out of trouble a recruit must adapt himself to this new environment.

This adaptation necessitates a special type of mind. The Army exists for one purpose, fighting. All else should be subordinated to that prime function. Men must adapt themselves, those less adaptable must be assisted. Those unable to adapt themselves will eventually be discharged, usually on psychological grounds.

One of the most striking changes of environment with which a man meets on joining the Army is the absence of privacy. In most civil lives, although absolute privacy does not exist, a man lives with those with whom he is friendly, or, at any rate, knows well. From the moment of entry into the Army, the recruit loses that privacy. He sleeps, eats and spends most of his day with men whom he has not known previously. Transferred to other units he again mixes with strangers. If he wants to be alone, he must walk alone. The solitary thinker, wishing to read or study, is "out of it". The peace-time Army is for those who are extraverts of the "hale-fellow-well-met" type, the companionable and the social type, the type that needs the support of others and is unhappy and uncomfortable working independently and individually. The late Sir William Robertson was ridiculed by his fellow troopers because he studied Army manuals in the evenings. The extravert, care-free recruit will therefore adapt more readily than will the introvert, solitary type.

Many boys are used to asking advice and assistance from their parents or siblings. Although men are generally helpful to the new-comer, the recruit must, within the first few days, learn that he must look after himself.

A boy brought up as an only son either by his parents or guardians, will be "lost" and perhaps ridiculed, until he realises this and acts accordingly. The recruit will thus become more independent. At the same time, he is becoming dependent, more of a whole that must be obeyed.

After the first few days of his new life, after he has become used to the novelty of his surroundings, the recruit will often feel the absence of relatives and friends. If he is fortunate, they will be near at hand and he may be able to visit them frequently. If he is sent some distance from home, he will miss them. Separation from those with whom he has lived for 16 or 18 years is not easy to overcome. For instance, a man took little interest in his duties. As he had a strong mother attachment he was depressed and worried. He had been brought up by his mother and was her only child. Consequently, instead of thinking about his work he was constantly desiring to return to his mother's protecting influence. Of course, the loneliness of separation is not felt by boys who have already been separated from their families, such as those brought up by Local Authorities or charitable organisations nor by those who have attended boarding school. Later will come the realisation that one has "signed on" for a number of years, and that one must remain "in this job". Five years, the difference between 18 and 23, is very great at 18 years of age. The difference between 20 and 25 years seems much less.

The attitude to property may seem unusual to the recruit. He will learn that there is a common belief that there is no harm in possessing more than the correct number of articles, provided that one has not "stolen" the excess. "Scrounging" or "acquiring" the articles does not matter. It is immaterial who loses. Inventories must be correct as regards stock, but excess stock is not necessarily found.

Still another aspect of Army life which is different from civil life is the method of inspection. An inspection is frequently announced previously. In civil life a manager may walk around his factory unexpected and at any time. The recruit will notice that often when an inspection is anticipated, a general smartening up and a higher state of efficiency is required. Instead of the standard required by the inspecting officer being maintained constantly, the recruit will notice that it is maintained only for the inspection. As the inspecting officer has been, when a junior, through the same process himself, he is clearly not deceived, but the policy of

being efficient for the sake of an inspecting officer and not because of a desire for efficiency is important.

Many recruits on entering the Army, are accustomed to the idea of Army life and much of the above does not apply. Those whose fathers were in the Army, or who have "mates" with whom they enlist, tend to be happier than the man who joins without a knowledge of military life.

Towards the end of a long term of service a man is often longing for his discharge. He may be disgruntled over real or imaginary grievances, and may tend to make the most of any illness in order to attempt to obtain an earlier and additional pension. Alternatively, if he has achieved much promotion and is fit he may wish to remain in the service. He may then be dissatisfied at retiring and lose interest in his work.

REASONS FOR ENLISTING

Men enlist in peace-time for a variety of reasons. Unemployment, a desire to travel, a desire for a regular job with regular money, the inbred love of military life, the wish to develop well physically and be made a man, may each be responsible for enlistment. In addition, at times of crisis such as Munich, September 1938, waves of men will join with a desire to help their country. Behind it all, is often the sub-conscious motive of inferiority. A soldier is taught to feel superior to a civilian. He is trained to think of himself as something fine. He is given smart coloured uniforms for walking out, and even in war-time, is allowed to wear coloured caps. He knows he may be given authority as an N.C.O. The cadet knows that he will have social and military prestige as an officer. These self-realizations compensate for any feelings of inferiority. Hence, men with strong inferiority feelings tend to join the Forces to be given authority necessary to overcome their inferiority. This process is usually unconscious. Nevertheless, the inferiority may still exist after joining the Army.

During War, reasons for enlisting are different. The man joins as a volunteer because he feels there is a job to do and he must "get on" with it. He is willing to sacrifice his comfort, his friends and his life. His masochistic desires to be a martyr are uppermost. Having joined he is keen to work hard and see results. He often hates the sadistic, killing side of war but perseveres wholeheartedly with bayonet practice as he knows it must be done.

The driving of a bayonet into a sack with perhaps crude drawings on it of a face repels many minds. Firing a rifle at an imitation man appears much less repulsive than driving a bayonet into him. It might be thought that with men brought up from childhood to be kind to others, training with a bayonet might be quite impossible, in practice this is not so. Although I have worked at two large infantry training centres for many months, I can recall one case only who considered his horror sufficiently great to mention it.

On the other hand, the young regular may never have visualised war. He may always have regarded his work as somewhat like "play-acting". He may have thought "War will never come whilst I serve". He may be worried when war breaks out.

The conscript joins because he must, but he may avoid conscription by volunteering previously. Many men will join before they are called up in order to make themselves feel nobler and to impress their friends. They did not wait to be fetched; others because they wish to choose the branch in which to serve. Amongst the general population the idea is prevalent that Army life is distasteful and men are surprised when they find that this is not so. Many conscripts, in different units, have told me that the Army is much better than they expected, and that they are getting on "all right". Others say that they like the life, and still others that the food is better than they were having in civil life. This in war time, when conditions in a rapidly expanding force are more hurried and must be less pleasant than in a force that remains of constant size.

The honest, conscripted, conscientious objector is in a different category. The great majority of those serving are willing, courteous and, provided that they are not ordered to bear arms, will carry out any duties allocated to them. Others, objecting to taking life, are regardless of their own lives, and volunteer for bomb disposal squads. A few appear irrational, and will not assist with the preparation of food, except their own.

Before joining the Army the conscientious objector may be very unhappy. If determined he will go to any lengths if he believes he will be forced to act against his principles. In one such case, an attack of acute depression occurred. The man's claim had failed, and he was ordered to report to a combatant unit. On the way, he locked himself in a public lavatory and cut his throat. Blood was seen coming from under the door, and he was found uncon-

scious. He recovered and gave a history of a previous, but milder attack of depression. The notice to report for duty had precipitated the severe attack with the accompanying attempted suicide.

The dishonest man who calls himself a conscientious objector should be dealt with as any other dishonest man. He may be difficult to detect, but will be disliked by the genuine objector and may be shown up for what he is.

On the outbreak of war the effect of mobilisation appeared to vary amongst the different classes. The reservists in peace consist of regular officers or men who have served a varying number of years, the Territorial who has served whole-time in annual training with Territorial units, the Supplementary Reservist, Category B, who has served whole-time with the regular units for annual training and for a longer period than the Territorial, and the Supplementary Reservist, Category C, who has joined as he is a specialist at his work, but has given no whole-time service as such. Some Territorials and Supplementary Reservists are old regular soldiers.

To the serving officers and men, mobilisation appeared to be a grim necessity, the regular reservist came up smart and with a smile. These reservists appeared to have a genuine desire to rejoin and "get on with things". The Supplementary Reservists gave the impression of being disturbed, of having been pulled suddenly out of bed in the early morning and still feeling somewhat dazed but willing to do whatever was required. At the medical inspection malingerers were conspicuous by their absence.

The effect of going over-seas was not marked. Hardly had the ship left the Solent and had passed the boom when she turned about and came inside again. A Belgian ship had been torpedoed by a submarine in the vicinity. But the effect on the men, both combatants and R.A.M.C. personnel, was little. Faces were solemn, jokes few and conversation tended to be on topics irrelevant to the situation. When the boat stations were detailed, lifebelts issued and iron rations distributed, the men were quiet, but shortly after, they were waving to pilots of passing 'planes and talking again. At night, the men lay crowded below deck, but the majority were calm and peacefully asleep. The officers appeared more restless. Few passed a good night, and most had but short periods of sleep. The old regular officers were more placid than were the Supplementary Reservists.

This same calmness was also noticeable after obvious danger,

with the possibility of danger to come. With the ship lying at anchor off-shore on a sea of glass, an enemy 'plane dived out of a cloud immediately over the vessel. The bomb missed its mark. For about seven hours more, the ship lay motionless in the same situation. The sun continued to shine and fleecy clouds to pass overhead. Yet few of the three thousand officers and men on board looked into the sky for further 'planes, liable to appear at any moment. Only one officer wore his life-belt, although most carried them. There was no air of nervousness, no restlessness or forced joking; and yet this occurred on leaving France, in a retiring Army.

A period of waiting, with comparatively little work, tends to give rise to numerous social difficulties. Men and women members of the Army in France became disinterested and felt their time was being wasted. They felt their services could be used to more advantage elsewhere. Monotony was relieved by a few dances, concerts and whist drives, but with nothing to occupy the time on so many evenings drunkenness tended to appear. As the weeks passed into months, a tendency was felt to become careless, the men needed more encouragement to stimulate their interest. Leave was earnestly looked forward to, but at home, some officers felt a sense of strain. Some said a feeling of relief occurred in them upon their return, although coming back in winter to canvas.

When the invasion of Holland began, spirits improved. Men became more alert and brisk as if waiting for something to happen. When air-raids occurred at night, only a few men in the camp became nervous.

The effect of fighting on men is variable. Whereas any man put to emotional strain sufficiently severe will break down, the majority of men are able to stand up to the strain of modern war.

Although we all enjoy, by definition, the pleasant rather than the unpleasant, some of us attempt, unconsciously and consciously, to avoid the unpleasant, particularly if the ideas are strongly objectionable. There are various methods by which the mind protects itself from these unpleasant processes. A common method is consciously to forget. This is normal though the facts can usually be recalled if required.

The facts forgotten may be actual events which the sufferer has witnessed or heard of, or may be figments of the imagination; ideas of his own of which he now feels ashamed or disapproves. The amnesia, as this gap in the memory is termed, can relate to

any ideas which have occurred in the mind. The patient forgets the unpleasant sensations he has received and has a blank period in the mind for which he cannot account. He usually forgets not only the incidents but also the events leading up to and possibly following the incident. There may thus be a gap in the memory of minutes, hours, days or weeks. Dual personality, in which the mind is evenly weighed on each pan and a slight emotional stimulus will tip down one side, is another form of amnesia. These periods of amnesia can usually be abolished and the gap closed by psycho-analysis, either in its long form continuing for months and years or with assistance of hypnosis or narcosis. These produce more rapid results than does the usual psycho-analysis. Thus a court making a decision on a case in which amnesia is claimed, may be completely deceived if the accused has not been previously investigated, for possibly a few weeks, by a competent medical psychologist.

Concussion is frequently associated with amnesia. The amnesia may both precede and succeed the concussion. That preceding it can usually be abolished by psycho-analysis. Frequently, it is produced by the realisation over a split second that the accident is about to occur. The horror of death apparently approaching forces the recollection out of the conscious mind.

Amnesia occurs in epilepsy although no major fit may take place. It is usually, but certainly not invariably, present for incidents occurring in sleep, such as walking, shouting or micturition. It is frequently present for the lesser of two or more incidents occurring simultaneously. The attention is focussed on the most important. This is well known when wounds occur during battle. The pain of the wound is not noticed until the emotional excitement of the greater danger is over. Thus after the explosion of a near-by bomb I found that, although my steel helmet was still on my head, my hair contained numerous pieces of stone. I have no recollection of the stones hitting my head, but I have a definite memory of feeling a smart blow on the back, presumably from the blast as my tunic was not marked. The entry of the stones in my hair would have occurred at the same time as the blow on the back, but the latter being painful, had taken my entire attention. Such lapses of memory frequently occur in witnesses of an accident, one item only being consciously recalled.

An officer was admitted to hospital in a very agitated state, much of his anxiety being due to the fact that he had an amnesia

for 24 hours, and was getting worried as to what he might have done during that time. He was a man with long service in the Indian Army. He could remember being in a stationary car during an air-raid, but nothing further until 24 hours later when he was walking in the road in which he lived. Under hypno-analysis all details of the period were obtained, the greater part of which was confirmed by the individual with whom he had been. As a bomb exploded, the car was lifted into the air and the driver had wanted to leave. The officer had insisted on the man driving, thinking it was safer to move than to remain where the next bomb might fall. He was driven to his house, sat up talking for a short time, went to bed and slept. The following day he went to his office as usual, and in the evening went to a variety show with a party. During the performance a violent paroxysm of trembling, resembling previous relapses of malaria, occurred. The officer was taken home. Although there were few outstanding emotional incidents in the 24 hours following the explosion of the bomb, the lifting of the car in the air with its tilting sideways, as if it were about to fall over, so terrified this officer that amnesia was produced. It should be added that this officer had seen active service on the Frontier and in the last war, and that he had been unperturbed during numerous raids in this country.

Another type of cause is shown by the following case where partial amnesia was present. A sergeant with 12 years Territorial service and 14 months whole-time service was blown up in the air by a trench mortar shell in France. Immediately after this, a tracer bullet had passed in front of his eyes. He stated he became quite blind, except for light and darkness, until three weeks after he had landed in the United Kingdom when the sight returned to the right eye. The sight of the left eye returned one week later. The amnesia was partial in that he could recall leaving a trench and bringing two wounded men within 20 yards of the trench. He could recall the tracer bullet passing in front of his eyes, being led back to the first-aid post and being in a lorry. He could not recall being in a second aid-post, but could remember going in an ambulance to a church which was bombed. He could recollect going to another building, being in a ship, but not being put on board. Under hypno-analysis, he recalled the whole period and the events leading up to his reaching the aid-post. Here, he recalled being given a dose of bromide. This could have produced drowsiness and periods of sleep so that he would be intermittently unaware of his

surroundings. The amnesia was associated with the sights he saw of the wounding and the death of the men he knew, including some who lived in the same street in his home town.

A complete amnesia for the former life is exemplified by the case of a man who, from the time of stepping off ship on returning to France from leave, had no recollection of anything previous. He knew his name and unit only from his documents. He presumed he must be married because he had several photographs of a woman with children. As he was admitted to a tented hospital, investigation was difficult. It had to be carried out in a ward of 20 beds with numerous noises, from the movement of the canvas and the other tents outside, interrupting the train of thought. Nevertheless, after one or two attempts, this man recalled a row of houses on one side of a street. These were unlike any he had seen in the only French village he had been in since he returned from leave. Unfortunately, owing to a sudden evacuation, the man was sent to the United Kingdom and was not able to be seen again. However, the fact that he began to recall memories showed that the memories were near the surface and that his case was not hopeless.

The amnesia which has not troubled the patient may become disturbing on account of a second event. A man opened the door of a small room with a jerk, and his loaded rifle in a corner exploded. This shock led to a persistent anxiety state. On discussion it was found that there was an amnesia for an event in France. On hypno-analysis the event was found to have been the explosion of a bomb which killed his "pal", blowing him on to the patient. The period of amnesia had been for a few seconds' duration only, but had been sufficient to give rise to symptoms when stimulated by a second, and unexpected explosion.

However, it must not be thought that analysis is required to recall buried memories in every case. In the majority of individuals, the memory returns without treatment. A personal experience well illustrates this point.

A bomb exploded on concrete about five yards outside a ward in which I was standing. For a few days after, I could recall the sound of the explosion, the pause during which I said to myself, "I must get down", kneeling down and the concrete falling around me. I could not recollect what I had been doing for half to one minute before the explosion. Without any conscious active steps on my own or other's parts, the short gap in my memory had been

filled within about ten days. The memory returned gradually, at first indistinctly, and then clearly. I recalled that I had been talking to an officer who was in bed and I had taken two or three steps toward the ward door when the explosion occurred. Similarly, partial amnesia may have been complete, but the patient has later, before examination, himself recovered some of the buried memories.

Another passive method of protection is by the development of hysterical paralysis. Here the mind, unconsciously, produces a paralysis so that the individual is no longer able to continue to carry out his duties. He may be genuinely desirous of continuing his work, but his unconscious mind protects him from the danger. He believes he is unable to move his limbs properly.

The formation of an amnesia is an event of a passive type, but the mind may attempt to protect itself in a more active manner by the development of fear. Fear, like amnesia, is protective, but protective in a sense of wishing to fly from danger, rather than by avoiding the unpleasantness. The feeling of fear in the presence of danger is a normal reaction, and those who never feel fear, if any such exist, are abnormal. They are defective. But fear can be illogical. It is then abnormal.

Abnormal fear may be based on fictitious danger; it may persist after the danger is past or it may exist because the danger has occurred even though the possibility of its recurring is remote.

Fictitious danger is due to some erroneous belief or to some buried memory which produces emotion without conscious cause. Fear of heights, of thunder, or open or closed spaces are examples. Fear of the dark is often deep-seated and based on a fear of ghosts or of being attacked. Because this fear has persisted from childhood into adult life, sentries may desert their posts. They may imagine men where there are only shadows, fire their rifles and show their positions to the enemy. One case in civil life had a fear of someone coming in at his bedroom door, in Army life, of an enemy coming into the tent. He quaked with fear until he was forced to go and talk to the man on guard. Fear persisting after danger has passed is usually due to an unconscious memory. The incident is forgotten that gave rise to the fear, but the emotion persists. Recollection of the memory usually abolishes that fear.

Fear existing because danger has occurred even though its recurrence is most unlikely, is very common. The man has perhaps been blown over or has seen unpleasant sights and, in all subse-

quent raids feels strongly afraid. He cannot appreciate that his belief that because something has happened once it is likely to occur again is not necessarily correct, and that to most individuals nothing terrifying occurs in raids. The emotional experience overcomes logic.

Fear is rapidly spread, and the example of one calm individual will help to quieten the fears of many.

The control of fear is important. It is quite definite that if fear is due to a buried memory, or an unconscious complex, that is an unconscious constellation of ideas, the anxiety is uncontrollable by the conscious mind. The mind does not know the reason for the anxiety and so cannot deal with the cause.

Control when the cause of the fear is known is certainly possible and is usually practiced by the majority when the degree is slight. When the fear has, however, grown intense with trembling, sweating and other concomitants, it is often uncontrollable. The lack of control is frequently due to lack of sleep. For days or weeks, the man has had reduced numbers of hours sleep. His determination is lessened and he cannot control his fear. Many hours of sleep daily improves his grip on himself and his fear decreases, providing he is still in the presence of danger. Obviously, the fear decreases or disappears if the man is moved from danger, although he may have a dread of a similar danger in the future.

When this conscious dread has disappeared, because of the cessation of danger, the emotional turmoil may lie dormant, but will wake up when the danger appears again, probably many years after the original fears.

For instance, a pilot who had crashed in 1917 and had since worked on the ground staff of an aerodrome, was compelled to fly for about $1\frac{1}{2}$ hours when going on leave in France in 1939, 32 years later. On getting out of the plane, an acute and severe attack of fear developed.

In some cases, adaptation to noise is difficult. A man who passed through continuous heavy bombardment for three weeks, remained quite well in a quiet remote Welsh village for a few weeks. Then, gradually, and progressively, he developed an aversion to noise. His comrades arguing or a door banging upset him until he was in a state of anxiety, not from the presence of danger, but from the noise. Similarly, men who tremble when guns are fired in practice may be afraid consciously of the noise as such, but not of the guns as instruments of death.

The line dividing cowardice and pathological fear is very difficult to define. The definition is distinct. A coward is a man who can control his fear, but will not, and the case of abnormal anxiety wishes to control his fear but cannot. Outwardly, the two appear similar. The treatment for both should be identical, providing they know the cause of their fear. Both should be placed in situations in which the danger occurs frequently, provided sufficient sleep can be ensured. The anxiety case will be given more opportunity to practise controlling his fear while the coward will appreciate that he gains nothing by not controlling it.

A decision after the event can be made only by the most painstaking and thorough investigation, the whole personality being considered. It can certainly not be made accurately or satisfactorily in open court. In certain cases, no doubt can exist in any reasonable mind. For instance, a regular sergeant with 15 years service had been dive-bombed and shaken in September 1940. He remained in the same area and passed through numerous raids continuously on duty. He was transferred to a quiet area for a few months, where no raids occurred and then to an area with frequent and severe raids. For about the first two nights he absented himself from the barracks and walked about the country. On the third day he was interviewed. He was ashamed of his behaviour, terrified lest his men should hear of it, and burst into tears when he recounted it.

On the other hand, men who say they are "nervous" during raids and have not been wounded or "blown up" previously, should be regarded with suspicion. Many of these could control their fear. Men, who while in actual danger, show no physical signs of fear, but say they are afraid should be ordered to control their fear. If fear is uncontrollable, physical signs will be present while the fear exists. Anticipation of further danger may perpetuate the signs.

The real amount of danger cannot be taken as a measure of the possibility of the control of fear. The power of control is dependent upon the ability which is possessed by the individual when he considers he is in grave danger. It is therefore a matter personal to the individual. Hence the impossibility of determining whether a man is a coward or not without consideration of his whole past life and temperamental qualities.

A fear of one type may raise up fears of another type. For instance, a man who was a painter, accustomed to ascending high

buildings, was blown over by a bomb and developed a fear of raids. At the same time, an intense fear of heights, from which he had never previously suffered, developed.

Amnesia can be produced, but can also be feigned. Although a different account given at a second interview may be due to the amnesia having been partly filled in spontaneously between the two examinations, a man giving a different report must be viewed with suspicion until his reliability is proved. Partial amnesia, during which certain incidents are remembered, can occur, but if during the period of claimed loss of memory customary actions are carried out at times different from the usual, it is unlikely that true amnesia is present. An instance of this was the case of an officer who stated he had lost his memory, but was found shaving at about 45 minutes after his usual hour. After the court martial had sat and judgment been passed, which was against this officer, he admitted that he had not been in a building which he reported as a vague memory during his amnesia.

Epilepsy is often cited as a cause of amnesia and amnesia definitely occurs in true epilepsy. Automatic and unremembered actions occur with and without the occurrence of major attacks of epilepsy. As fits can be simulated so easily and schools have been found which train men to imitate epilepsy, it is essential that a diagnosis should be made accurately out of court. The ease with which major attacks can be imitated is shown by the case of an imbecile with a mental age of about nine years, who could "throw a fit" for a penny so accurately that junior members of the nursing staff of the mental hospital were deceived. On the other hand, the presence of epileptics in the Army can be a serious danger in war. A man who is liable to have a fit may make a noise in falling and draw machine-gun fire, or may be unconscious after being placed on guard. Although in peace-time the risks to their comrades are not great, these men will be sent over-seas on the outbreak of war. One such case, a Grenadier Guardsman, sent back from the front line, had fallen on his bayonet and cut his chin while on guard at St. James's Palace before the outbreak of war.

The over-conscientious, efficient officer is a type who is so keen to make the best of his job, that he does not take leave, believing that he is indispensable to his unit. He may be keen because he fears higher authority or fears lest he be reduced while holding acting or temporary rank, or it may be solely because he must be efficient in order to overcome his own feeling of inferiority. What-

ever the reason, he will continue to work without sparing himself, until he makes mistakes. These mistakes may be criminal or less important, but an efficient officer who deteriorates should always be treated sympathetically, his senior officer who has omitted to order him to take leave, or occasional half-days away from his duty, should be treated in an entirely different manner. It is the responsibility of the senior to keep his subordinates healthy and not to flag the willing horse. Killing the goose that lays the golden egg is a poor policy.

Re-employed or retired officers who are placed in positions similar to those they previously held are particularly liable to break down and make mistakes. A man efficient in 1917 at 26 years of age as a lieutenant-colonel broke down after 5 months as a company commander in 1940. He had taken command of the most inefficient company of the battalion and brought it up to be the most efficient, but had allowed himself no leave or time off while doing so.

The temperamentally unstable man is frequently found. He may be defective in adequate reasoning power, so that he fails to realise that persistently making trouble for himself is not in his own interest, or he may be the victim of bad upbringing. He is unstable in that his emotions are swayed by events which on the average individual would have little effect. A minor event appears to him to be major. He will, therefore, lose his temper over trivialities. He may cry readily. He may suddenly leave his unit.

These men, while apparently intelligent and able to learn, are frequently on charges of absence without leave, or of using abusive language, of drunkenness, of carelessness in matters of equipment. Military regulations to them are of less value than are their emotional urges.

As in fear and cowardice, the problem in this case is to decide whether the man can or cannot control his emotions. Only by a private interview, with particulars of his past life, can a reliable estimate be formed. The work record is important, frequent posts held for short periods being of significance, although rapid changes may be due to poor intellectual development.

The mental defective, if of a comparatively low grade, is easily recognised even by commanding officers of large units, but the higher grades are usually missed. They are regarded as simple-minded souls, which they are, and are placed on simple fatigues. At such work in peace-time they are frequently capable and

thorough, but their characteristic that they are incapable of dealing with unusual situations is likely to cause danger and trouble in war. A defective on guard may be clumsy, giving his position away to the enemy. He may be unable to read details on an identity card and allow an officer to pass through with an incorrect card. He may leave his post for some unnecessary reason, as, in the case of one, who walked about 200 yards to a latrine, when his post was situated amidst bushes. Another defective having forgotten to wake a member of the guard who was to have woken the camp cook, himself walked away to wake the cook. Consequently, a prisoner escaped.

A defective who is of a nervous disposition may fire a rifle at an imaginary enemy, especially in the half-light of dawn when stationary shadows may to an ordinary individual appear to be moving. The danger of a nervous defective on guard is exemplified by the case of a brigadier visiting a battery and being stopped by a sentry who asked for his identity card. This was produced and the brigadier then said: "I have a revolver here and could shoot you. Where is your rifle?" "Aw," replied the sentry, "That's behind 'ere. I scared o' that."

The higher defective has a one-track mind. If trained he is a good worker, but he cannot adapt to new situations or think out unusual courses of action. He lacks foresight.

The defective is often slovenly and dirty, but this may not be noticed for a prolonged period. A friend may "mother him", seeing that he is on parade punctually, and that he is clean and tidy. In one case, this process continued for nine months until the friend was transferred to another unit. Within a few days the defective was noticed.

The man who is frequently on charges of fairly trivial offences is often a high grade defective. He cannot remember how to avoid trouble and cannot appreciate that if he omits or commits certain acts he will be detected. As he is not sufficiently clever to avoid detection he is, of course, charged frequently.

Malingering has, in this war, been very rarely seen. No doubt this is due to the high morale of the nation. Many men unconsciously and consciously exaggerate symptoms, some to obtain a greater amount of sympathy, and others to draw attention to their genuine underlying illnesses, which they consider, are receiving insufficient attention.

CRIME

Whilst in the forces an officer or man is still subject to civil law and can be prosecuted in a civil court. Nevertheless, there are additional crimes which can be committed by the soldier. A list of offences which might be committed when the accused is psychologically abnormal is given at the end of this article. Military offences more likely to be committed by the normal person and not so likely to be due to psychological abnormality have been omitted.

The commission of crimes can be divided, from a psychological aspect, into three main groups, the passive, the active and the neutral. The passive is that in which a person allows himself to be led or persuaded by another individual into the omission or commission of a criminal act, the active in which he initiates or independently avoids the act. In the neutral type the person is neither led by another nor misguided by himself. He commits a crime by being neutral, as when ignorant of the law, apathetic or disinterested in the results of his act.

With the exception of, perhaps, negligently occasioning false alarms and losing by neglect items of equipment or property, all crime could be caused by abnormal psychological states and either could be active or passive. Negligently occasioning false alarms and losing articles by neglect would come under the group of neutral causes. It is clear that owing to the attention being occupied, either actively or passively, by other matters, neglect may ensue, but the abnormal psychological cause would not primarily be neglect, but matters withdrawing the attention and producing neglect.

The following crimes, besides being committed either actively or passively, could also be placed in the neutral group: Sleeping on a post, failing to inform the Commanding Officer of mutiny or sedition, failing to give notice to the Commanding Officer of desertion or take steps to apprehend a deserter, absence without leave, failing to appear at a place of parade or rendezvous, being found in a place prohibited by order, absence from school, behaving in a scandalous manner, being concerned in or conniving at, misapplication of regimental money or goods, receiving stolen or embezzled money or goods, without reasonable excuse allowing a person to escape, being concerned in making away with

equipment or property, omitting to send a report or return, failing to discharge as speedily as possible transport, permitting the compelling of a person in charge of transport to take thereon baggage, stores or person (not sick), permitting the ill-treatment of person in charge of transport, after being discharged with disgrace re-enlisting without declaring circumstances of discharge or dismissal, being concerned in the enlistment of a man whom he knew had reasonable cause to believe would commit an offence by enlisting, declaring military information which would produce injurious effect on His Majesty's service, unlawfully detaining pay, committing disorder or neglect prejudicial to good order and military discipline. In each of these crimes, regarded as neutral crimes, the commission is the omission.

The giving of all possible reasons for the commission or omission of the crimes enumerated would necessitate the complete exposition of medical psychology, but some few abnormal states may be mentioned.

A person with low intelligence, who is dull and not fully developed mentally, would be likely to commit neutral crimes, whereas a person of normal intelligence would be less likely to do so. He might be influenced by a delusion, that is an illogical idea, which he, honestly, believed to be true. If a man in the dim half-light believed a friend to be an enemy and shot him, it would be a very regrettable mistake, but he would be unlikely to be charged with murder. If the same man, in the bright day-light, believed the friend was an enemy because he had been told that the enemy were in British uniforms and would operate from that direction, again he would be unlikely to be charged with murder. If, however, the same man possessed a delusional idea that all men who came from that direction must be enemies, he would be held responsible for the death of the man until proved insane. In other words, if someone else put the wrong idea in his mind, he would not be held responsible, if he put it in himself, he would be held responsible until the contrary was proved. A man stronger-minded than another, could persuade a weaker man to surrender his post to the enemy. Who, from a common-sense stand-point would be to blame? Surely the man who conceived the idea of surrender and who initiated the plan. In law the man who surrendered the post would certainly be responsible. The argument may be made that the commander should have withstood the persuasion and acted on his own judgment, but this ignores the power

which a stronger-minded man may have over a man with less determination. This weakness of character is particularly evident in, of course, other types of crime, especially in definite cases of mental deficiency. The majority of these cases are easily led into right or wrong ways. From these dull or feeble-minded men up to the most determined of men there is a gradually increasing scale. In spite of this scale of degrees of determination, each individual varies around his basic amount according to the circumstances of the time. If he has lost much sleep, if he is psychologically fatigued, he will be likely to be less determined in his own mind, although he may be more irritable and act impulsively so resembling greater determination. Psychologically, he will be unable to stand such continuous strain and still form a sound judgment. He will be liable to make mistakes, the seriousness of them being dependent upon the type of decision which he has to make. If a man has to decide whether to scrub a floor in the morning or afternoon and has all day in which to do it, a mistake in selecting his time is not of great importance. If he chooses an hour in the afternoon, forgetting he should be on parade at that time, the mistake is more important. Similarly, in more responsible positions an error of judgment made by a commanding officer may mean the loss of a few lives or of many thousands. In every case, the mind makes an error, but the consequences are of varying importance. It is necessary for the mind to be working well to reduce errors to the minimum. The working of the mind below its usual standard of efficiency may be due to physical fatigue, mental disorder or drugs giving temporary emotional imbalance. Imbalance is seen psychologically, in the cycloid type of individual whose temperament varies from depression of varying degree, to joyousness. Perhaps for hours, perhaps for years, the prevailing mood is one of depression, but this passes off to be succeeded by one of happiness, a feeling that life is good. This phase goes in turn and is replaced by one of depression.

Temporary emotional upset occurs after any emotional event. At the play, in the cinema or whilst reading a novel, emotional changes take place. An assessment must be made as to whether these temporary emotional crises are so great that they are beyond the quantity of emotion felt by the average individual for the particular existing cause. On the one hand, if a man becomes markedly depressed or cries after a mild reprimand, he is possibly over emotional. On the other hand, if a man is repeatedly

punished and does not cease committing the misdemeanours, it follows that he is not sufficiently swayed by the punishment to overcome his desires. Consequently, either he wishes to control his feelings and cannot, or else he prefers the punishment to the cessation of his acts. In either case, there is no object in continuing the punishment as it is not preventing the man from committing further crimes. He should be investigated psychologically. In many cases, a man is legally responsible for a crime, as he knew the nature and the quality of the act and knew the act was wrong. Nevertheless, although the man is guilty, there may be mitigating circumstances in his emotional make-up which should reduce the punishment awarded. To the average man certain external events would not influence his actions, but to the temperamentally unstable individual the same events would sway him to commit a crime. Therefore, mitigating circumstances are present in the criminal, not in his external surroundings. Lord Atkin's Committee went further than this when it proposed that "it should be recognised that a person charged criminally with an offence is irresponsible for his act when the act is committed under an impulse which the prisoner was by mental disease in substance deprived of any power to resist". Whether a person can, or cannot, resist a desire can only be determined by studying carefully and minutely his past behaviour and past life. This may take an hour or more, particularly if evidence confirming some of his statements must be obtained. The investigation is almost valueless if it is concerned only with the act with which he is charged. The accused's whole character and outlook must be determined in order to assess his controllable reaction to the particular environment existing at the time the act was committed. Such assessments can be computed accurately only by a trained and experienced person. Any person can make the assessment to his own satisfaction, but only a highly trained individual can make the assessment reliably. If put to work above his capacity an intellectually defective man will frequently become over-emotional, depressed and apathetic or defiant. For instance, a man may not be able to retain in his memory all the duties of a tank crew, or of the numbers on a light anti-aircraft gun or the theory of electricity taught in searchlight work, but he may be quite capable of learning the duties of six positions on a field gun. If he is of a slightly lower grade, he may be capable of carrying out the duties of one number on the heavy guns used in coastal defence. The know-

ledge of one number only may be all that is required of him for he can be replaced from the reserve watch or the watch off duty. A man of a still lower standard of intelligence may be capable of labouring work only. A defective put to work of which he is capable will usually be content and will not be likely to commit crime. Those who feel they are misunderstood do so, over-compensating in a defiant way for their own incapacity and inferiority. Another temporary emotional upset occurs in men who believe that their wives are too frequently with other men. Consequently, in order to put matters right at home, they frequently go absent without leave or may malingering. The last occurs especially in peace-time when a soldier serving overseas feigns illness in order to be sent to his home in England. Although men say they do not believe anonymous letters with reference to their wives, there is frequently a feeling of doubt stirred up by these letters. In some cases, other evidence tends to confirm the suspicions. In one case, for a week or two preceding the receipt of an anonymous letter saying that his wife was inviting soldiers to the house, the wife had been writing to her husband once a week instead of daily.

The law exists for the harmonious and efficient administration of the Army and to reduce unnecessary disturbances to the minimum. Consequently, the retention of trouble makers, making trouble for themselves and others, should cease as early as possible. The discharge of the voluntarily enlisted criminal over the age of 41 years is one course to adopt, but such cases are rare. All men who appear unable to reach the standard of their unit or who are too frequently in minor or major trouble should be referred for psychological investigation at the earliest opportunity.

Some notes on the working of the law may be added. For instance, disobedience, to be culpable, must be the disobeying of a lawful command. The disobedience must tend to impede, prevent or delay a military proceeding. If the soldier is ordered to work in a private garden, he may lawfully refuse to carry out the work. With regard to desertion and absence without leave, intent to leave the Army must be present before a soldier can be convicted of the former. Absence without leave refers to absence from the place of duty, even though the soldier may be in the same building. Malingering can be present only if illness is feigned in order to escape duty. If no duty can be avoided the charge will be one of feigning disease or infirmity. Extra guards or piquets can be ordered as a minor punishment when on or parading for these

duties. They may be given to private soldiers for similar reasons on His Majesty's ships. Acts, conduct, disorder or neglect to the prejudice of good order and military discipline can include any of the more minor offences or even the repetition of baseless complaints. Examples of crimes which can be brought up under the section as given in the Manual of Military Law are the passing of worthless cheques, the negligent performance of duties with regard to money or stores, improper possession of public property belonging to officer or comrade, being away from place of duty, sleeping out instead of in billet, the use of government car or petrol for private purposes, borrowing money from subordinates, using a false medical certificate, using a false leave pass, wearing uniform medals, rank or ribbon when not entitled to do so, giving a false name to the police, accepting gifts as an inducement for arranging or excusing duties, being unfit for duty owing to alcohol, negligently wounding oneself, obtaining money for railway warrant or ticket, improperly obtaining "concession vouchers", improperly using or obtaining railway warrant or ticket, repetition of baseless complaints or the making of complaints framed as to be offensive or indicative of insubordination.

A sentence can be suspended. When such suspension is in force, the soldier is free unless his sentence is put into force for misbehaviour.

When suspension is being considered special attention is to be given as to whether the offence is premeditated, whether the man was subjected at the time to any special stress, fatigue, disability or temptation or whether he was influenced by others older or of worse character than himself.

Under suspension of sentence, first offenders can be dealt with leniently to give them opportunity to avoid further misbehaviour.

Military law is fair and full consideration is given to the accused. Even a conscientious objector in the Army, who had been convicted on several occasions of various misdemeanours, informed me that he had been treated fairly at each conviction, and that there was nothing about which he either could, or wished to complain.

Whether the immense amount of time spent by combatant officers in the preparation of cases for trial and court martial is justified in war-time is a matter of opinion. One view is that justice and fair play must be continued in war as in peace, so that every effort should be made to make the trial fair. The other is

that officers should not spend so much time on relatively worthless men when there is so much time needed to train worthy men. Clearly this is a matter of general policy.

This brief account of reactions to military life is necessarily incomplete. It gives a few findings from personal observation. Many other matters could be discussed, but the application of general psychological principles will cover the majority of these other aspects.

LIST OF OFFENCES IN RESPECT OF MILITARY SERVICE

(Extracted from the Manual of Military Law, 1940, p. 704, *et seq.*)

Shamefully { abandoning
delivering up { a garrison.
a place.
a post.
a guard.

Using means to { compel { a governor
induce { a commanding officer } shamefully to
(or other person)

{ abandon { a garrison
deliver up { a place
a post
a guard } which it was his duty to defend.

Shamefully casting away his { arms
ammunition } in the presence of the enemy.
tools

Treacherously { holding correspondence with } the enemy.
giving intelligence to

Treacherously
Through cowardice } sending a flag of truce to the enemy.

Assisting the enemy with { arms.
ammunition.
supplies.

Knowingly { harbouring } an enemy not being a prisoner.
protecting

Having been made a prisoner of war, voluntarily { serving with } the enemy.
aiding

Knowingly doing, when on active service, an act { His Majesty's Forces.
calculated to imperil the success of } part of His Majesty's Forces.

Misbehaving
Inducing others to misbehave { before the enemy in such manner as to show
cowardice.

When on active service wilfully { destroying } property without orders from his
damaging } superior officer.

When on active service being taken prisoner { by want of due precaution.
through disobedience of orders.
through wilful neglect of duty.

After being taken prisoner when on active service, failing to rejoin His Majesty's Service when able to rejoin same.

When on active service, { holding correspondence with
without due authority { giving intelligence to
sending a flag of truce to } the enemy.

When on active service { by word of mouth
in writing
by signals
(otherwise) } spreading reports
calculated to
create unnecessary } alarm.
despondency.

When on active service, leaving his { guard
picquet
patrol
post } without orders from his superior officer.

When on active service, by { discharging firearms
drawing swords
beating drums
making signals
using words
any means whatever } intentionally
occasioning { in action.
on the march.
in the field.
elsewhere.

When on active service, { parole
making known the { watchword
countersign } to a person not entitled to receive it.

When on active service, { parole
treacherously giving a { watchword
countersign } different from what he received.

When a soldier acting as sentinel (on active service) leaving his post before regularly relieved.

When on active service leaving his commanding officer to go in search of plunder.

When on active service { forcing
striking } a sentinel.

When on active service breaking into a house } in search of plunder.
(other place)

When a soldier is acting as sentinel } sleeping at his post.
(on active service) } being drunk at his post.

By { discharging firearms
drawing swords
beating drums
making signals
using words
(any means whatever) } negligently occasioning { in action
on the march
in the field
(elsewhere) }

making known the { parole
watchword
countersign } to a person not entitled to receive it.

Without good and sufficient cause { parole
giving a watchword } different from what he received.
countersign

Impeding { the provost-marshal
an assistant provost-marshal
an officer
a non-commissioned officer
(other person) } legally exercising { under
on behalf } the provost-
authority of marshal.

When called on, { the provost-marshal
refusing to assist an assistant provost-
in the execution marshal
of his duty an officer
a non-commissioned
officer
(other person) } legally exercising { under
on behalf } the provost-
authority of marshal.

Doing violence to a person bringing { provisions
supplies } to the forces.

Committing an offence { property } of an inhabitant { in the country in which
against the person } of a resident { he was serving.

Irregularly { detaining
appropriating } corps { contrary to
to his own battalion orders issued in { pro-
detachment that respect visions } proceed-
ing to the
forces.

Causing
Conspiring with other { a mutiny } in His Majesty's { military forces.
persons to cause sedition } naval forces.
air forces.

Endeavouring to seduce a { military forces
person in His Majesty's naval forces } from allegiance to His Majesty.
air forces

Endeavouring to persuade a { military forces
person in His Majesty's naval forces } to join in { a mutiny.
air forces sedition.

Joining in { a mutiny } in forces belonging to { military forces.
sedition } His Majesty's { naval forces.
air forces.

Being present at and not using his { a mutiny } in forces belonging { military forces.
utmost endeavours to suppress sedition } to His Majesty's { naval forces.
air forces.

After coming to the { an actual mutiny } in forces
knowledge of { an intended mutiny } belonging
actual sedition to His
intended sedition Majesty's

{ military forces
naval forces } failing to inform without delay his
air forces commanding officer of the same.

Striking
Using violence to } his superior officer, being in the execution of his office.
Offering violence to }

When on active service $\left\{ \begin{array}{l} \text{striking} \\ \text{using violence to} \\ \text{offering violence to} \end{array} \right\}$ his superior officer.

When on active service using $\left\{ \begin{array}{l} \text{threatening} \\ \text{insubordinate} \end{array} \right\}$ language to his superior officer.

Disobeying in such a manner as to show wilful defiance of authority of a lawful command given by his superior officer in the execution of his office.

When on active service, disobeying a lawful command given by his superior officer.

When concerned in a $\left\{ \begin{array}{l} \text{quarrel} \\ \text{fray} \\ \text{disorder} \end{array} \right\} \left\{ \begin{array}{l} \text{refusing to obey} \\ \text{striking} \\ \text{using violence to} \\ \text{offering violence to} \end{array} \right\}$ an officer who ordered him into arrest.

Striking
Using violence to
Offering violence to $\left. \vphantom{\begin{array}{l} \text{Striking} \\ \text{Using violence to} \\ \text{Offering violence to} \end{array}} \right\}$ a person in whose custody he was placed.

Resisting an officer whose duty it was $\left\{ \begin{array}{l} \text{to apprehend him.} \\ \text{to have him in charge.} \end{array} \right\}$

Breaking out of $\left\{ \begin{array}{l} \text{barracks.} \\ \text{camp.} \\ \text{quarters.} \end{array} \right\}$

Neglecting to obey $\left\{ \begin{array}{l} \text{general} \\ \text{garrison} \\ \text{(other)} \end{array} \right\}$ orders.

When on active service $\left\{ \begin{array}{l} \text{deserting His Majesty's service.} \\ \text{attempting to desert His Majesty's service.} \end{array} \right\}$

Assisting a person subject to military law to desert His Majesty's service.

When cognisant of $\left\{ \begin{array}{l} \text{the desertion} \\ \text{the intended} \\ \text{desertion} \end{array} \right\}$ of a person subject to military law not forthwith

$\left\{ \begin{array}{l} \text{giving notice to his commanding} \\ \text{officer} \\ \text{taking some steps in his power} \\ \text{to cause the} \end{array} \right\} \left\{ \begin{array}{l} \text{deserter} \\ \text{intended} \\ \text{deserter} \end{array} \right\}$ to be apprehended.

Absenting himself without leave.

Failing to appear at the place of $\left\{ \begin{array}{l} \text{parade} \\ \text{rendezvous} \end{array} \right\}$ appointed by his commanding officer.

Without leave, before he was relieved, $\left\{ \begin{array}{l} \text{parade} \\ \text{rendezvous} \end{array} \right\}$ appointed by his commanding officer.
going from the place of

Without urgent necessity, quitting the ranks.

When in camp
When in garrison
When elsewhere $\left. \vphantom{\begin{array}{l} \text{When in camp} \\ \text{When in garrison} \\ \text{When elsewhere} \end{array}} \right\}$ being $\left\{ \begin{array}{l} \text{beyond the limit fixed by} \\ \text{found in a place prohibited by} \end{array} \right\}$

$\left\{ \begin{array}{l} \text{general} \\ \text{garrison} \\ \text{(other)} \end{array} \right\}$ orders, without pass or written leave from his commanding officer.

Without leave from his commanding officer, or due cause, absenting himself from school when duly ordered to attend there.

Behaving in a scandalous manner, unbecoming the character of an officer and a gentleman.

When charged with } the care } of public } money }
When concerned in } the distribution } of regimental } goods }

being concerned in the } stealing }
conniving at the } fraudulent } thereof.
misapplication }
embezzlement }

When charged with { the care } of public { goods, wilfully damaging
When concerned in { the distribution } of regimental { the same.

Malingering.

Feigning } disease.
Producing } infirmity.

Wilfully { maiming { himself } with
injuring { a person } intent
subject to } thereby } himself } unfit for service.
military law } to render } that }
person }

Causing himself to be { maimed } by some person with intent thereby to render
injured } himself unfit for service.

Being wilfully guilty of misconduct } he { produced } disease.
by means of which misconduct } aggravated } infirmity.
Wilfully disobeying orders by means } delayed the }
of which disobedience } cure of }

Stealing { money { the property of a person subject to military law.
Embezzling { goods { belonging to a regimental { mess.
Fraudulently { public money. } band.
misapplying { public goods. } institution.
belonging to the Navy, Army, Air Force institutions.

Receiving { money { the property of a person subject to military law.
knowing } stolen } belonging to a regimental { mess.
them } embezzled } goods { band.
to be } public money. } institution.
belonging to the Navy, Army, Air Force
Institutions.
public goods.

Such an offence of a fraudulent nature as is mentioned in paragraph five of section eighteen of the Army Act.

Disgraceful conduct of { a cruel } kind.
an indecent }
an unnatural }

Drunkenness.

Wilfully
without
reasonable
excuse } allowing to escape a person { committed to his charge } guard.
whom it was his duty to } keep.

When in { arrest
confinement
prison
other lawful
custody } escaping.
attempting to escape.

Making away with by
Being concerned in
making away with by { pawning
selling
destruction
or
otherwise } { his arms.
his ammunition.
his equipment.
his instruments.
his clothing.
his regimental necessities.
a horse of which he has charge.
public property issued to him for his use.
public property entrusted to his care for
military purposes.

Losing by neglect { his arms.
his ammunition.
his equipment.
his instruments.
his clothing.
his regimental necessities.
a horse of which he has charge.
public property issued to him for his use.
public property entrusted to his care for military purposes.

Making away with by { pawning
selling
destruction
(or otherwise) } { a military
an air force } decoration granted to him.

Wilfully injuring { his arms.
his ammunition.
his equipment.
his instruments.
his clothing.
his regimental necessities.
a horse of which he has charge.
public property issued to him for his use.
public property entrusted to his care for military purposes.
a military decoration granted to him.
an air force decoration granted to him.
property belonging to { a comrade.
an officer.
a regimental mess.
a regimental band.
a regimental institution.
public property.

Ill-treating { a horse
other animal } used in public service.

Taking
Knowingly suffering } from a person { money } for { excusing }
to be taken { a reward } { relieving }

a person from { his liability } in respect { billeting } of { officers. }
a part of { his liability } of the { quartering } { soldiers. }
horses.

Offering { menace to { a constable } to make him give billets contrary to the }
Using { compulsion on { a civil officer } Army Act. }

Using { menace to { a constable }
Offering { compulsion on { a civil officer }
tending to { defer } him from performing } his duty under the
discourage } part of } provisions of the
tending to induce him to something } Army Act relat-
contrary to } ing to billeting.

Using { menace to
Offering { compulsion on } a person tending to oblige him

{ to receive without his consent, a person not } the provisions of the
duly billeted upon him in pursuance of } Army Act relating
to furnish some accommodation which he } to billeting.
was not required to furnish by }

Wilfully demanding { carriages } which are not actually required for the purposes
animals } authorised by the Army Act.
vessels }
food }
forage }
stores }

Constraining { a carriage } furnished in pursuance of { to travel, against the will of }
an animal } the provisions of the } the person in charge there-
a vessel } Army Act relating to } of, beyond the proper dis-
riages } the impressment of car- } tance.
riages } riages } to carry, against the will of }
riages } the person in charge there-
riages } of, a greater weight than }
riages } he was required by the }
riages } said provisions to carry. }

Failing to discharge as speedily { a carriage } furnished in the pursuance of the Army }
as practicable { an animal } Act relating to the impressment of }
a vessel } carriages. }

Compelling
Permitting the } a person in charge of { a carriage }
compelling of { an animal }
a vessel }
furnished in pursuance with } baggage } not entitled to be
the provisions of the Army } stores } carried.
Act relating to the im- } though not furnished { soldier } who
pressment of carriages to } on a requisition of { servant } was
take thereon } emergency or { woman } not
person } sick.

Ill-treating
Permitting the } a person in charge of { a carriage } furnished in pursuance with
ill-treatment of { an animal } the provisions of the Army }
a vessel } Act relating to the im-
pressment of carriages. }

XII

THE DIAGNOSIS AND TREATMENT OF DELINQUENCY

(BEING A CLINICAL REPORT ON THE WORK OF THE
INSTITUTE FOR THE SCIENTIFIC TREATMENT
OF DELINQUENCY, DURING THE FIVE YEARS
1937-1941)

By DR. EDWARD GLOVER

THE work of the Institute for the Scientific Treatment of Delinquency can best be appreciated by reviewing briefly the history of its development.¹ The idea of founding an Institute was stimulated by the results of a psychological investigation conducted in certain prisons, preventive and rescue homes. The research was carried out by a medical psychologist, Dr. Grace Pailthorpe, on behalf of the Medical Research Council and with the co-operation of the Home Office.² Her report indicated very clearly the possibility of applying scientific methods of diagnosis and treatment to cases serving a prison sentence, and a small committee was soon formed to explore the possibility of applying these methods also to cases on remand or on probation. Finally, in 1932, the I.S.T.D. was founded having as its chief aim the provision of facilities for examination and, where possible, treatment of cases of anti-social conduct especially among young people. It was felt that although a certain amount of psychological treatment was already available at a few clinics, it was desirable to build up an organisation devoted exclusively to work on delinquency. The committee then proceeded to form a panel of doctors willing to give their services. The West End Hospital for Nervous Diseases generously offered the use of a room and agreed to make physical examinations of cases referred to the Institute. From

¹ I wish to acknowledge my indebtedness to Miss I. M. James, General Secretary to the Institute, and to Miss G. M. Wilcox, Psychiatric Social Worker to the Psychopathic Clinic, without whose skilled and tireless assistance this Report could not have been compiled. I am also indebted to Miss M. B. Stott for permission to use some of her research material.

² *The Psychology of Delinquency: Studies in*, by G. W. Pailthorpe, M.D., Medical Research Council Report, No. 170, H.M.S.O., 1932, 2/-

these slender beginnings the Institute grew from 1932 to 1936 when it became obvious that only a considerable expansion would enable the staff to cope with the increased demand for their services. As the result of a public appeal for funds a Clinic was opened in 1937 with adequate equipment for the examination, diagnosis and treatment of delinquent out-patients. Apart from this purely clinical development, the Institute was able to expand its activities in a number of other directions, in particular the education of public opinion, the provision of training facilities for students and the organisation of clinical centres in the Provinces. From the first the need for accurate psychological diagnosis and treatment was a paramount consideration, and the original staff panel included psychological experts drawn from the various schools of medical psychology. But the founders of the Institute were determined to avoid the pitfall of exclusively psychological or sociological interpretation and to develop a plan of research which would cover the diagnostic and therapeutic fields adequately. This policy was reflected in the creation of a department for mental measurement, the appointment of a psychiatric social worker, and the establishment of auxiliary services of physical examination at convenient specialist centres, viz. other clinics or hospital centres. Nevertheless, the bulk of the work done by the Clinic and Institute still lies in the psychological field.

PART I.—CLINICAL MATERIAL

It is necessary to emphasise the fact that the clinical material handled by the Institute is already selected before recommendation, consequently that the statistics of the I.S.T.D. are not valid for the delinquent population as a whole. In particular the *sources of referral* must be taken into account. Almost from the beginning the majority of cases have come from Police Courts. Either magistrates ask for a report before the case is proceeded with, or Probation Officers ask for assistance with cases already on probation. A large number are also referred by medical practitioners, by other psychological clinics and by philanthropic societies; the remainder are recommended by relatives, friends, social workers, employers and solicitors. Some of these are no doubt recommended to us because the peculiarity of their conduct calls for psychological diagnosis; others again are sent to the Clinic as a last resource before imprisonment, but in the majority of instances cases are sent

because it seems likely that they will prove amenable to psychological treatment. From time to time, particularly when the work of the Institute has received some publicity, a few patients refer themselves, usually in the hope of avoiding a relapse into delinquent conduct. The relative importance of these groups can be gathered from the following Table, covering the period 1937-1941 inclusive. During the first three of these years the Clinic was working to full peace-time capacity; during 1940-41 the effects of war conditions first manifested themselves.

Sources	1937	1938	1939	1940	1941
Courts and Probation Officers	92	106	112	65	71
Medical Practitioners and Clinics	34	24	26	8	5
Philanthropic Societies ..	13	9	7	33	10
Relatives and Friends ..	16	11	6	4	9
Social Workers, Employers, Defence, etc.	7	6	7	4	6
Patients referring themselves ..	5	2	1	0	1
	167	158	159	114	102
Add old cases re-opened but classified in former years ..	0	8	6	0	5
Total Cases Referred	167	166	165	114	107

The variation in total referrals since 1937 is due to the following circumstances: (1) in 1938 the Munich crisis occasioned a decline in referrals for about a month; (2) from January 1939 to the outbreak of war there was an increase, 138 cases having been sent before September. Under normal conditions, therefore, the total for the whole year would have shown a considerable increase. As, however, the clinic was closed for a month in September, the figures for 1939 cover only eleven working months; (3) similarly, in 1940 the figures do not represent a full working year. During the worst period of enemy air raids work was brought almost to a standstill; a time-bomb put the clinic out of action for several weeks in the autumn and ultimately necessitated removal to new premises. Other factors contributing to the drop in numbers were the call-up of men for military service (affecting patients and medical staff alike); evacuation, increased pressure of work upon

the already severely taxed probation service and the closing for a period of all but one Juvenile Court in the London area; (4) on the outbreak of war the "blackout" and the reduction in medical staff made it necessary to discontinue evening clinics. Increasing pressure of war-work made it extremely difficult for probationers (even juveniles) to attend for treatment during the day.¹

Sources.—In spite of the variation in total referrals, it is to be noted that throughout the period 1938–1941 the proportion of cases referred from the Courts has remained at a satisfactory level, the percentages for these years being: 1937, 55·09 per cent.; 1938, 67 per cent.; 1939, 70·5 per cent.; 1940, 57 per cent., and 1941, 69·61 per cent. The smaller number of cases referred by other clinics since the war is probably due to the fact that during the latter part of 1940 most of the London hospitals and clinics were temporarily out of action, and even difficult to locate. The same factors account partly for the rise in referrals from philanthropic societies, the I.S.T.D. being one of the few clinics to continue work in London at that time. Many cases presenting behaviour problems were referred by Refugee Societies. Apart from this the Table requires correction for age, sex and type of offender, since, particularly in the case of court recommendations, the number of variables mounts rapidly. Courts and Probation Officers seem to take three factors into consideration; the age of the offender, the seriousness (from the legal aspect) of the offence and the number of known previous offences any one case may have committed. For example, although magistrates on the whole realise that sexual offenders may benefit by a psychological approach and tend to send such types of offender to the Institute, they rarely send cases of the "solitary shoplifter" type whose delinquency (particularly amongst the middle-aged) suggests a psychological origin. As the majority of our cases are referred from Courts, it follows that most of the clinical material comes in the younger age groups and is constituted of persons committed for offences of a comparatively light nature without any official history of recidivism. These selective factors are not, however, very dependable. Subsequent examination frequently shows, for example, that cases with an official record of two or more recent offences have, unknown to the police, a history of anti-social behaviour dating from childhood.

¹ Additional medical staff have been appointed in order to overcome this difficulty; but the absence of many of the most active members of our regular staff on war service has very seriously curtailed our facilities for treatment.

SEX AND AGE DISTRIBUTION

A. (All cases).—In 1938 national statistics for males of all ages found guilty of indictable offences in England and Wales compared with those of females of all ages under similar conditions, showed that fifteen per cent. (15%) were committed by women. In the Institute's report for the same year the proportion of women referred was slightly over twenty-seven per cent. (27%), as the following Table shows:

A. ALL CASES

Age	1937			1938			1939			1940			1941		
	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.	M.	F.	T.
Under 17	35	8	43	39	10	49	44	10	54	65	12	77	49	14	63
Over 17	103	21	124	85	24	109	85	20	105	29	8	37	17	22	39
Old Cases															
Re-opened			0			8			6			0			5
	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
	138	29	167	124	34	166	129	30	165	94	20	114	66	36	107

As was anticipated on the outbreak of war an increase in the number of patients under 17 years of age occurred in 1940, the percentage being for that year 67·5 as compared with 25·75 per cent. in 1937, 31 per cent. in 1938, 33·9 per cent. in 1939, and 58·88 in 1941. In comparing these percentages, however, due regard must be given to the decrease in adult male cases due to war circumstances.

B. Juvenile Cases Only (aged 5-17).—For purposes of comparison we include a special Table for Juveniles only, and we have selected two complete working years, one under peace-time, the other under war-time conditions:

Age	1938			1941		
	Male	Female	Total	Male	Female	Total
Under 11	2	0	2	8	4	12
11-14 ..	6	0	6	7	3	10
14-17 ..	31	10	41	34	7	41
	—	—	—	—	—	—
	39	10	49	49	14	63

It will be noted that the average age of Juvenile Delinquents sent to the Institute is higher than the rate for the general population.

This is largely accounted for by the fact that the younger child cases are usually sent by probation officers to the nearest Child Guidance Clinic and possibly also to the fact that the more difficult *pubertal* types are sent to the Institute. It is generally true that when a psychological clinic sets out to expand new lines of treatment it soon gets saddled with intractable cases. In delinquency clinics, however, this applies more to juvenile types. As has been noted, Courts do not usually send adult recidivists either for examination or for treatment.

So much public notice has been given to increase in juvenile delinquency during war-time, that, although the subject does not strictly speaking come within the scope of this Report, some provisional comment may be justified. In the first place, study of officially approved records goes to show that there was a *pre-war* increase as well as a war-time increase in juvenile delinquency. It also suggests that the basic causal factors are not due to "war conditions", but that war conditions act as a precipitating factor. It would perhaps be more accurate to say that war-time conditions provide a suitable culture medium for the growth of delinquent reactions, the ultimate causes of which are essentially intrinsic. Some confusion has arisen owing to the fact that the authorities seem to have lost sight of the pre-war increase and have taken to the view that the increase is only a war-time phenomenon. In our Annual Reports we have stressed the necessity of suspending conclusions as to the nature of war-time "waves" of delinquency. There has so far been no opportunity of conducting a reasonably scientific investigation of the problem, and, in war-time there is always a risk of accepting *ad hoc* explanations as scientific data. It seems likely that, in juvenile cases at any rate, a combination of two factors is responsible for war-time delinquency. These are, first, a serious disturbance of previously stable family relations, due, for example, to evacuation, absence of parents in the services or in war factories, blitz conditions, etc., and second, a history of early maladaptation to family life due either to internal psychological causes or to unsatisfactory conditions of upbringing.

Types of Offence.—Below we give two Tables showing types of offence (A) for all cases, and (B) for juveniles only:

¹ Breaking and Entering; Found on Enclosed Premises; In need of Care and Protection; Wilful Damage; Truancy; Refusing to return to Duty; Receiving; Drunk; Insulting Behaviour; Abandoning Child; Uttering a False Statement; Indecent conversation on telephone; Non-Delinquent.

A. ALL CASES

	1937	1938	1939	1940	1941
Theft	79	76	61	49	52
Sex cases	45	46	54	15	14
Embezzlement, False Pretences, Forgery	14	5	11	1	0
Behaviour Problems	—	—	—	30	14
Beyond Control	—	12	12	5	6
Shoplifting	3	2	0	0	1
Attempted Suicide	1	2	1	0	0
Wandering	—	1	2	1	0
Violence	—	1	0	3	0
Persistent Cruelty	—	2	0	0	0
Infanticide	—	—	—	—	1
Others (from 1940 on, classified as under) ¹	25	11	18	10	14
	167	158	159	114	102
Add old cases reopened but classified in former years ..	0	8	6	0	5
	167	166	165	114	107

B. JUVENILES

	Under 11		11-14		14-17		Total	
	'38	'41	'38	'41	'38	'41	'38	'41
Theft	1	4	4	7	20	22	25	33
Behaviour Problems	—	5	—	2	—	4	—	11
Beyond Control	1	0	0	1	10	5	11	6
Sex cases	0	1	0	0	10	5	10	6
Receiving	—	0	—	0	—	1	—	1
Breaking and Entering	0	1	1	0	0	3	1	4
Being on enclosed pre- mises	0	—	1	—	0	—	1	—
In need of Care and Pro- tection	—	1	—	0	—	0	—	1
Truancy	—	0	—	0	—	1	—	1
Falsely giving a fire alarm and damaging public property ..	0	—	0	—	1	—	1	—
	—	—	—	—	—	—	—	—
	2	12	6	10	41	41	49	63

¹ For footnote see previous page.

An alteration in nomenclature accounts for the drop in 1940 in "Beyond Control" cases; that title is now employed only for cases so charged in a Juvenile Court, the new heading "Behaviour Problem" being used where no Court action is taken. These two groups together, however, represent 30·7 per cent. of 1940 cases, whereas in 1938 and 1939 "Beyond Control" cases were only 7·5 of the yearly totals. In 1941 "Behaviour Problems" were 13·73 per cent., and "Beyond Control" 5·88 per cent. of the total. In 1937 such cases were classified among "Others". The decline in the proportion of sex cases since the war (comparative percentages, 1937, 26·95 per cent.; 1938, 29·1 per cent.; 1939, 33·9 per cent.; 1940, 13·1 per cent.; 1941, 13·73 per cent.) is closely related to decline in adult referrals. The proportion of theft cases does not show such a marked variation.

PART II.—DIAGNOSIS

The aim and scope of the diagnostic methods employed will be more clearly grasped by setting out first of all a table of *Diagnostic Groups*. This "medical" diagnosis can be usefully compared with the "legal" (or "social") diagnosis already given under "Types of Offence".

In 1940 a new group labelled "Behaviour Problems" was included. A few such cases had previously been included under "Character Cases", but the increasing number of juveniles referred justified a separate classification for those cases in which sexual perversion, gross neurotic changes, and manifestations of predominately psychopathic tendencies are absent. These "Behaviour Problems" are mostly cases in which some acute difficulty in adaptation to the environment has caused abnormal behaviour, but where it seems likely that the tendency to maladjustment is not ingrained. As might be expected many of these cases fall in the pubertal age-group. Stresses in early adolescence due to the sudden augmentation of psycho-sexual impulse are frequently expressed through anti-social reactions. These are readily amenable to psychological orientation or treatment. For the sake of simplicity, wherever a case could be placed in more than one group, it is classified in the above table in accordance with the most important factor.

In case the distinction between "non-delinquent" and "normal" types should seem superfluous, it should be remembered that

A. ALL CASES

	1937	1938	1939	1940	1941
Mentally defective	4	0	5	6	5
Borderline mentally defective	12	10	22	3	7
Psychotic	7	2	2	1	1
Borderline Psychotic	14	4	9	3	1
Psychoneurotic	48	54	32	34	37
Character cases (including psychopathic personalities and sex perverts apart from neurosis)	58	56	59	42	43
Behaviour Problems	—	—	—	11	0
Cases of organic origin ..	1	9	7	7	1
Non-delinquent	—	7	11	4	1
Normal	6	0	0	0	2
Alcoholic	2	0	2	1	3
Failed to complete investigation	15	16	10	2	1
	167	158	159	114	102
Add old cases re-opened but classified in former years ..	0	8	6	0	5
	167	166	165	114	107

B. JUVENILE DIAGNOSTIC GROUPS

	Under 11		11-14		14-17		Total	
	'38	'41	'38	'41	'38	'41	'38	'41
Mentally Defective ..	—	1	—	0	—	2	—	3
Borderline „ ..	0	2	2	1	5	2	7	5
Borderline Psychotic ..	0	1	0	0	2	0	2	1
Psychoneurotic ..	0	5	2	7	13	15	15	27
Character Cases ..	0	1	1	1	15	7	16	9
Psychopathic Personality	0	1	0	1	1	12	1	14
Sex Pervert	0	—	0	—	1	—	1	—
Normal	1	0	1	0	1	2	3	2
Organic	0	—	0	—	1	—	1	—
Non-delinquent ..	—	1	—	0	—	0	—	1
Failed appointment ..	1	0	0	0	2	1	3	1
	2	12	6	10	41	41	49	63

cases are sometimes sent, as a rule, from private sources, where the conduct alleged proves to have been non-delinquent—attempted suicide, for example. Examination, however, may disclose some other form of abnormality. If no abnormality of any sort can be detected the case is classified as “normal”, meaning, of course, normal at the time of examination, and likely to remain so.

In arriving at the diagnosis of “psychoneurotic delinquency”, two standards are adopted: either the patient has suffered or still suffers from a simple psychoneurosis (*e.g.* anxiety states, conversion hysteria or obsessional neurosis) to which the delinquent act, however important socially, is, psychologically regarded, a secondary reaction; or, the delinquent act itself is hysterical (or obsessional) in character, in other words is a “social symptom” or “Character reaction” identical in nature with a private psychoneurotic symptom. The best example is, of course, the case of genuine kleptomania in which the delinquent act is identical with an obsessional act in all but two respects, viz. that society is attacked in some way or another and that the punishment courted is not, as in the true neurotic case, an “unconscious self-punishment” but a real punishment inflicted by society. One might quote by way of illustration the case of a young adolescent who made a practice of stealing bicycles which he neither sold nor converted to his own use, merely parking them in suitable hiding-places; or that of a young man who had had a compulsive interest in shining leather objects since childhood, but who did not get into trouble until he started snatching dog-leashes in the streets: and only then when the leash happened to be of the right colour and texture.

The “psychopathic character” group includes persons whose faulty emotional development has given rise to various forms of unstable and abnormal behaviour some of which are, legally regarded, delinquent. These must be distinguished on the one hand from the classical manifestations of neurosis or psychosis, and on the other from the manifestations previously described under the heading “Behaviour Problems”. The latter are less bizarre and more transient in nature. It is found convenient to include in the psychopathic group persons suffering from some form or other of sexual abnormality or perversion which is classed by the community as delinquent. Although sexual delinquencies are easily diagnosed, they are by no means easy to place as regards either the severity of the infliction or its relation to the total personality. The

group is indeed a difficult one in almost every sense of the term, psychogenetic, prognostic and therapeutic.

As far as juvenile groups are concerned, it should be noted that diagnosis of psychosis is no easy matter. The younger the case the more difficult it is. Manifest symptoms, easy to detect in adults, are "covered" during childhood by character defences; many juvenile cases diagnosed as "psychopathic characters" would if followed up no doubt be diagnosed as psychotic in later life. Most of the "beyond control" cases come in the pubertal age group. As has been noted, pubertal difficulties give rise not only to sexual misdemeanours, but to a great variety of anti-social and anti-familial reactions, of which being "out of control" is only one. In the majority of cases these are transient in nature. The "social" diagnosis of stealing (theft, larceny, etc.) is even less suitable for juvenile than for adult groups. It is essential, for example, to distinguish at all times between "theft at home", "theft from friends or relations" and "theft from strangers", also between "theft of private property" and "theft of public property". In the past much too little attention has been paid to the classification of different forms of theft, to say nothing of their relation to burglary. Research on this subject is overdue.

Obviously it would be desirable to have some standard grouping that would meet the needs of both "medical" and "social" diagnosis, but in the meantime that is neither possible nor practicable. The list of "legal diagnoses", for example, is always headed by the "theft" group; yet on medical analysis this large group must be split up and its constituents distributed among a number of medical groupings—neurotic, psychotic, organic, etc. Only by so doing can accurate or adequate disposal be effected. Again, sex cases fall naturally into a single group, yet from the point of view of etiology and prognosis it is more convenient to include these cases in the psychopathic character group. Moreover, it would be unreasonable to expect "legal diagnosis" to bring out environmental or organic factors: yet it is essential to successful treatment that the medical diagnosis should do so. No doubt in future the courts will adopt many medical distinctions that are at present ignored by them, and medical investigators will no doubt give more weight to behaviouristic aspects of offence singled out by the courts. Already kleptomania is distinguished by the courts from ordinary pilfering, and clinic physicians in their turn are ready to recognise the medical aspects of the "beyond control" group.

But the advances made in these directions are so far rudimentary.

Diagnostic Methods.—As the reader may have surmised from the Diagnostic Table, each patient is seen as soon as possible after referral by a psychiatric social worker, a medical psychologist, an educational psychologist and an organic physician. If necessary, supplementary examinations are made by a psychiatrist, a vocational guidance officer and a variety of organic specialists. This complicated series of examinations has been found to give rise to a number of practical difficulties. Ideally speaking, it is desirable that the series should be completed as rapidly as possible; also that the delinquent should be seen in the first instance by a clinical psychologist, thereby affording an opportunity to establish rapport between the delinquent and the clinic. This, however, is not always practicable, and the role of “leading personality” is frequently taken over by the Psychiatric Social Worker who acts also as liaison officer between the other examiners and with the Director responsible for the Final Report and Recommendations as to Disposal or Treatment. In some cases the social worker can secure an adequate history from the delinquent’s family, friends, employer, or from public authorities (*e.g.* school or police), and so be in a position to “prime” the clinical psychologist as to previous history and environmental factors before he sees the case. Ideally speaking, two steps should be taken on the day of arrival. The clinical psychologist should examine the patient and, while this examination is taking place, the psychiatric social worker, having already in her possession the relevant “social documents”, should interview the relations. But some overlap of function as between the social worker and the clinical psychologist is frequently inevitable. To avoid scattering the patient’s “transferences” too much, this situation should be dealt with as tactfully as possible. Where, however, the examining psychiatrist intends to act also as psychotherapist, it is essential that he should become the leading personality as soon as possible after the patient’s referral from the Court.

Apart from considerations of order, the following points should be added regarding the aim and technique of the various contacts with the delinquent. To take the social history first: it is hardly necessary to say that this work is invaluable to everyone concerned at every stage of the proceedings. The number and variety of “social” interviews necessary has already been indicated. Their

aim may be summed up as follows: it is to obtain an "external life story"—a psycho-sociological account of the *environmental influences* impinging on the delinquent up to the date of commission of the offence. From this account also a good deal can be surmised as to the *pattern* of his previous behaviour and as to the main outlines of his *character*. These surmises can be checked by the clinical psychologist who, in addition to giving the patient a complete psychological overhaul, fills up inevitable gaps in the social history. Space forbids any detailed account of this overhaul, for which the reader must refer to current textbooks. But it is interesting to note that although the medical staff is drawn from different schools of clinical psychology, this fact gives rise to comparatively little difficulty in diagnosis. To prevent error examining psychologists keep as nearly as possible to the outlines indicated in the case form: if corrections are necessary, these can be made without much difficulty by the Report Director when he surveys the whole dossier.

With regard to supplementary examinations the following are the most common types of referral: to an organic specialist, *e.g.* for X-ray, endocrine investigation, examination of eyes, teeth, etc.; to a psychiatrist for a special opinion on cases suspected of psychosis; and, should the intelligence tests suggest unusual ability, to a Vocational Guidance expert for recommendations as to employment.

The intelligence test usually given is the Binet-Simon test (Terman-Merrill revision), an oral test of the question and answer type. This is sometimes supplemented by (and occasionally superseded by) a printed verbal test, or a test of a non-verbal type. The aim of these tests is to throw light upon the individual's capacity for adjustment to life from a cognitive point of view. They also help in arriving at a diagnosis and in deciding as to disposal or treatment. They enable the psychiatrist to estimate the extent to which past environment (social, educational and occupational) has been adapted to the capacity of the individual, and the degree of adjustment that will be necessary in the future. They may help, too, in differential diagnosis, *e.g.* as between a mental defective and a schizophrenic patient (small range and childish responses as opposed to a wide scatter and bizarre replies). The tests also make it easier to assess temperamental qualities, *e.g.* powers of concentration, easy discouragement, persistence, etc.

In many cases one or more Performance Tests (Matrix, etc.) are

also given. These are sometimes helpful in uncovering or confirming occupational unsuitability, *e.g.* when an individual has been struggling to achieve the impossible, or when he is thwarted by an occupation affording him too little intellectual outlet. Their greatest service lies in promoting the elimination of occupations grossly unsuitable from the point of view of intelligence. Sometimes it is possible for the tester to suggest general lines of occupations which seem preferable to those previously followed. Owing to the time and equipment involved it has not, however, been found practicable to give a vocational guidance consultation, though occasionally a few supplementary vocational guidance tests have been given.¹ Apart from these routine uses, intelligence testing has also been used to clear up problems arising in the case of delinquent patients who are handicapped in employment by *e.g.* tone deafness, left-handedness, stammering, etc.

From the point of view of research, intelligence testing of delinquents has already proved its utility. Miss M. B. Stott, for example, examined some 54 cases which she had tested at the I.S.T.D. during 1939–1940, in order to make a comparative study of the mental age of these delinquents. She found that the highest incidence of “crime” was amongst the definitely “dull” age-group, *i.e.* those with an I.Q. between 80–90. The “high intelligence” group (over 110 I.Q.) came second, whilst the “average” group (90–110 I.Q.) were well below the other groups in numbers. The actual case figures were: dull group, 24; superior group, 18; average group, 12; total, 54.

PART III.—FINAL REPORT AND RECOMMENDATIONS

When the examination is complete the file is brought to the Director by the clinic psychiatric social worker. The former then co-ordinates the various findings, if necessary referring back to previous examiners for additional information. In his report the Director endeavours to keep to a definite order; he indicates the relative importance of the environmental, psychological and organic factors relevant to the case, and gives his provisional diagnosis in terms that will be clear to the Court or other persons referring, *i.e.* as far as possible in non-technical language. A recom-

¹ The National Institute of Industrial Psychology has co-operated with us in investigating specially difficult cases.

mendation as to disposal follows and the reasons for this are added. These reasons are again stated in terms of the various psychological and other factors previously described. The scope of the report can be understood more easily by studying the following Table of Recommendations after Diagnosis.

TABLE OF RECOMMENDATIONS

	1940	1941
Patients requiring:		
Psychotherapy	63	68
Psychological Observation	9	3
Institutional Treatment:		
Mental Hospital, V.P.	3	3
Certification	2	0
Under the M.D. Act	2	2
Approved School, Borstal	2	2
Home for Inebriates	0	1
Organic Treatment	7	0
Environmental changes (home, school, work, etc.)	17	16
Supervision (social or probationary)	6	9
Not suitable for treatment (non-delinquent)	2	2
Failed to complete diagnosis through war circumstances	1	1
	<hr/> 114	<hr/> 107

The following points are worthy of comment. The Director has constantly in mind not only the difficulty magistrates may have in giving expression to the essentially clinical findings of the Institute, but also the practical difficulties court officials may encounter when seeking to administer court decisions. Two simple cases may be cited: first, when the patient's need of psychological treatment conflicts with the needs of society (*e.g.* the need for segregation or close supervision); second, when the needs of the patient call at the same time for psychological treatment and special employment which cannot be secured within visiting range of the Clinic. In both instances the question of priority is given much thought. If a reasonable compromise seems possible, this is indicated, the final decision being left to the Court.¹

¹ No doubt many of these difficulties could be overcome by the provision of hostels under the control of the I.S.T.D. (see Part VIII).

Generally speaking, it is true to say that the easier the diagnosis, the easier it is to make a recommendation, though not necessarily one that will be easy for the Court to adopt or carry out. In roughly 45 per cent. of all cases a reliable diagnosis can be arrived at with comparative ease and rapidity. This group includes the majority of psychoneurotic (average percentage for five years, 29.29 per cent.), defective (2.86 per cent.), borderline defective (7.71 per cent.), and organic types (2.14 per cent.). Borderline psychotic cases (4.43 per cent.) come into the difficult group along with the majority of psychopaths (36.86 per cent.), and behaviour problems (average percentage, for two years only, 5.09). As has been noted sexual offenders are included in the psychopathic group, but it should be remembered that although their sexual *symptoms* are easy to recognise their general mental state is by no means easy to diagnose.

It will be obvious that where delinquency is secondary to factors such as endocrine imbalance, head injuries, encephalitis lethargica, epilepsy, obsessional neurosis, mental deficiency, psychosis, etc., the proper course is to recommend whatever form of clinical treatment is indicated. From this point of view the recommendation in borderline psychotic cases presents little difficulty. Where the situation is complicated by social factors (need for segregation, certification, special education at an Approved School or special forms of employment), it may be necessary to depart to some extent from a strictly ideal course. But the ideal course should always be stated. The recommendations for cases that come in the "difficult" diagnostic groups are in most instances compromises, and by no means easy to arrive at.

PART IV.—DISPOSAL

As has been pointed out the actual disposal of cases does not invariably follow the lines indicated in the recommendation. Naturally, the ultimate disposal is a matter for the Court. Even if the Court, as is very often the case, gives effect to the recommendation, a number of social or domestic obstacles may present themselves. For example, if we take the last two years we find that although in 1940 55.26 of the new cases were recommended treatment, only 32.46 actually received it. The corresponding figures for 1941 are 63.55 and 38.32. Nevertheless, each year an increasing number of delinquents are put on probation with the

condition of undergoing psychological treatment, as the following percentages of *new* cases treated show: 1937, 29·34 per cent.; 1938, 26·51 per cent.; 1939, 30·91 per cent.; 1940, 32·46 per cent., and 1941, 38·32 per cent. For a number of reasons it is desirable to distinguish between those given psychological treatment (with or without conditions) and cases where other methods of disposal only are effected. For instance, the treatment given at the Institute is exclusively psychological in nature, and it is essential that the results obtained should be considered separately.

In the Tables set out below this course has been adopted. It should not be lightly assumed, however, that "social" forms of disposal do not constitute "treatment" in the psychological sense. In actual fact, a good deal of the probation officer's work consists of advising, befriending and assisting the delinquent as distinct from supervising his life. Some of these activities do not differ in any essential respect from the psychotherapeutic devices known as persuasion, re-education, etc. Indeed, in a sense it might be said that all the procedures adopted by society (including Court proceedings, sentence, etc.) depend for their effects—good, bad or indifferent—upon the psychological influences they exert on the mind of the delinquent.

It will be noted that the numbers "Refusing Treatment" in 1937 and 1938 are disproportionately large. There are two reasons for this. During these years, cases "Failing to complete Diagnosis" were included under the former heading; secondly, owing to shortage of staff many cases had to wait for weeks, occasionally months, before vacancies could be found for them. When a vacancy did occur, the patient was sometimes no longer prepared or able to accept it. The apparently high rate of cases "Not suitable for psychological treatment" from 1937 to 1939 is due to the system of classification then in use. In 1937 cases recommended organic treatment, probationary care, environmental changes, etc., were included under this heading. The present classification first came into effect during 1938, but not soon enough to reduce the total substantially. "Institutional supervision" is a new heading since 1940. In previous years the group was labelled "Patients referred to other Institutions", and in 1937-8 the group included cases sent to hostels. These are now classified under "Environmental changes". The heading "Institutional supervision", therefore, does not fit all five years. Disposal to "Approved Schools" is difficult to classify. Strictly speaking, it is an institutional recom-

TABLE OF DISPOSALS (new cases only, including old cases reopened)

	1937	1938	1939	1940	1941
A. Psychological Treatment or Observation at Clinic.					
Awaiting Treatment at 31st Dec.	49	44	51	37	41
Awaiting Observation at 31st Dec.	24	16	4	3	7
Evening Waiting List suspended 3rd Sept., 1939			21		
B. Other forms of Disposal:					
Referred elsewhere for psychological treatment . .	—	—	—	1	2
Unable to accept treatment or other recommendation through circumstances . .	—	—	—	0	4
Unable to accept treatment or other recommendation through war circumstances	—	—	—	17	0
Refused treatment or other recommendation . .	24	17	5	6	6
Relapsed before treatment	6	5	2	0	0
Not suitable for psychological treatment	23	22	29	2	1
Organic treatment . .	—	6	7	8	0
Institutional Treatment: . .	27	23	12		
Certified (by other authorities)	1	0	0	4	0
Mental Hospital . .				1	2
Mentally Defective . .				1	4
Borstal or App. School . .				3	2
Segregation	—	3	0	0	0
Probationary care only . .	—	9	5	4	1
Care and Supervision . .	—	—	—	1	0
Environmental changes (school, foster home, work, etc.)	—	11	14	22	26
Sentenced	—	—	—	—	2
Failed to complete investigation	—	—	5	1	3
Awaiting diagnosis 31st Dec.	13	10	10	3	6
	<u>167</u>	<u>166</u>	<u>165</u>	<u>114</u>	<u>107</u>

mendation yet cannot be regarded in the same light as the certification of psychotics and mental defectives. The cases sent are as a rule psychopathic in type. The numbers included under the heading "Environmental changes" are influenced by war conditions. Figures for the current year are not available, but already there has been a marked increase in the number of school children sent to the Clinic. Many had been returned from reception areas as "unbilleteable", and were referred to the Clinic as "behaviour problems". Disposal has consisted largely in arranging for new or more suitable foster homes preferably within reach of a Child Guidance Clinic. Incidentally, it should be noted that a good deal of the actual work of disposal is undertaken by our Psychiatric Social Worker, working in concert with the Probation Officer and other officials concerned. As will be seen later, this work is of considerable therapeutic value, and if staff permitted could be amplified in almost every direction. In particular it is desirable that arrangements should be made after *personal interview* with the parties concerned, parents, teachers, employers, etc. On occasion our social worker is in an even better position than the probation officer to effect suitable disposal, and to pave the way for a smooth contact between the delinquent and his environment.

PART V.—PSYCHOLOGICAL TREATMENT

The treatment given at the Institute is exclusively psychological in nature, and includes the usual range of *techniques* from pure suggestion and hypnosis to psycho-analysis. Techniques of "open" suggestion are frequently combined with indirect methods, *e.g.* persuasion, exhortation, re-education, etc. The psycho-analytic method is reserved for specially selected cases. In a great number of cases "combined" methods are employed. Various types of psychological analysis (as distinct from pure psycho-analysis) are combined with degrees of guidance, persuasion, etc. Many cases, particularly those in the pubertal age group, are given advice and instruction only. "Psychological observation", although strictly speaking a long term diagnostic procedure, is also therapeutic in aim. The observation interviews afford useful opportunities to give instruction and advice and to effect, on occasion, quite considerable reorientations. The following figures give some measure of the Clinic's therapeutic activities.

NUMBER OF THERAPEUTIC SESSIONS (of all cases
treated during the year, but excluding diagnostic
and Psychiatric Social Worker's interviews)

Year	Interviews	Average
1937	1314	12.06
1938	1256	12.44
1939	963	9.17
1940	497	7.65
1941	607	9.95

As will be seen, war conditions led to a reduction in the average *duration* of treatment. This is due almost entirely to shortage of staff, which in turn has compelled the more extensive use of "short term" methods. In any case, the averages are rather misleading. Cases calling for psychological treatment fall into two main groups (1) those requiring intensive psychotherapy of, say, from fifty to several hundred interviews duration. Longer methods can be used only occasionally; (2) those requiring short psychotherapy or simple psychiatric handling and advice. Treatment of this latter group occupies from five to fifty interviews approximately; these, however, may be scattered over a long period.

Selection of Cases.—As has been pointed out, cases sent to the Clinic have already undergone a process of selection, *e.g.* by probation officers who, as a rule, recommend cases likely, in their opinion, to respond to treatment. A further process of selection is carried out at the Clinic. In earlier years this was influenced by experience gained in the field of general medical psychology. Thus it was assumed that psychoneurotic types of delinquency would respond most favourably and rapidly to appropriate psychological treatment. Character types were regarded as more refractory to psychotherapy. Results obtained with delinquent cases show, however, that character types also respond well to treatment. It should be added that the intelligence quotient, although of considerable diagnostic value, is not so effective as a criterion of suitability for treatment. Some backward delinquent children may respond to treatment better than many who are definitely intellectual in type. Again, although pubertal types in the "Behaviour Problem" or "Beyond Control" group are readily amenable to treatment, it is also true to say that sexual offences in men

of varying age are often treated with considerable success. Apart from the age distribution for different types of offence, the length of time during which the delinquent traits have been manifested must be taken into account. As might be expected the outlook for chronic cases and "recidivists after treatment" is not generally favourable, unless, of course, the patient is a compulsive (obsessional) type, when repetition of the offence is an important part of the pathological "system".

The foregoing considerations have an important bearing on a problem confronting all clinics that are occupied with research as well as with treatment, viz. the *policy* of selection. If, as has been indicated, cases, previously regarded as refractory to treatment, prove to be more amenable than had been anticipated, it would seem desirable to devote therapeutic attention to so-called "incurable recidivists". It is by now a commonplace of mental pathology that study of "hopeless" cases throws a good deal of light on mental development even of normal people. The advanced case of insanity, for example, affords valuable information regarding infantile stages of development. Hence even if the therapeutic results were negligible, it is likely that study of the refractory types of delinquent would lead to the discovery of more effective methods of handling those milder cases that so far have been the main concern of this Institute. It would of course be necessary to keep independent records of such experiments, otherwise the therapeutic results in "suitable" cases would be unfairly watered down by "failures". On the other hand there is a limit to the amount of work that can be done even by the most devoted voluntary staff, and since those who refer cases naturally expect that favourable cases should get the benefit of treatment, the problem of allocation is not easy.

Although "organic types" are sent elsewhere for physical treatment, the psychological bearing of minor physical ailments, or of defects in physique (either congenital or the result of faulty development) is not lost sight of. Undersized or physically deformed children, children whose pubertal phase is either delayed or premature, or who suffer from other endocrinological abnormalities, often display delinquent reactions. Asocial conduct during, or shortly after, pregnancy has also been observed. In any case, psychological reactions complicating organic illness are of considerable significance. The bearing of this on the selection of cases is obvious. Not only has correction (or amelioration) of physical defects a part to play in psychotherapeutic systems, but correction

of psychological reactions to physical abnormalities has a part to play in the treatment of organic delinquent types.

To sum up: it is probable that the quality of the personality, the strength of the will-to-recovery and the degree of potential rapport with the psychotherapist, constitute the three main factors on the strength of which the degree of suitability can best be determined. Nevertheless, it must be said that the number of factors affecting selection makes it difficult to draw general conclusions as to suitability, or as to the relative utility of different methods of psychotherapy. The form of treatment chosen is also influenced by a number of clinical and social factors. For example, even if, as would appear to be the case, intensive treatment by some form of analytical therapy produces the most satisfactory and/or lasting results, it is nevertheless impossible to give intensive treatment to the majority of cases attending the Clinic. Most delinquents have to earn their own living. They may be able to attend only once a week, and then only if the psychotherapist can see them after working hours. Under war conditions, evening sessions have not been practicable.¹

PART VI. RESULTS

Discharges.—The following table gives a general survey of the results (a) for total cases given psychological treatment at the Clinic (marked "T" in the Table), and (b) for new cases treated in each year (marked "N").

The use of the term "Recovered" implies that some fundamental cause of the delinquency has been discovered and treated satisfactorily; for example, a mental disease of which the offence is symptomatic, or an unusual and specially traumatic environmental factor in an individual who otherwise would have remained normal. For obvious reasons the current year's discharges under this heading are never likely to be high. For example, of the total of 15 so discharged in 1939, 10 were admitted in 1938, 2 in 1937, and 2 before 1937.

The term "improved" is intended to indicate that the patient has reached a stable non-delinquent state, although the causes of his delinquency were of such a kind that it would not be justifiable to claim a "cure" until a period of some years had elapsed. The

¹ In June, 1942, evening work was resumed experimentally, but the success of the venture cannot yet be estimated.

TABLE OF DISCHARGES OF CASES TREATED

	1937		1938		1939		1940		1941	
	T.	N.	T.	N.	T.	N.	T.	N.	T.	N.
Recovered	7	1	7	4	15	1	2	2	2	2
Improved	28	6	26	6	28	10	9	2	5	1
Unimproved	2	0	0	0	5	3	0	0	0	0
Discharging self ..	20	8	12	3	9	5	7	1	10	6
Discharged through war circumstances (army, evacuation, war work, etc.) ..							28	14	13	1
For other reasons ..	2	2	8	1	8	1	5	1	13	8
Transferred elsewhere after some treatment	3	0	1	1	0	0	2	0	1	1
Relapsed during treat- ment	3	2	2	2	1	0	0	0	1	1
Treatment suspended 3.9.39					21	16				
Observations suspended 3.9.39					2	0				
Still under treatment 31st Dec.	44	30	43	25	15	12	18	14	29	20
Still under Observa- tion	—	—	2	2	3	3	4	3	1	1
	—	—	—	—	—	—	—	—	—	—
	109	49	101	44	107	51	75	37	75	41

“non-delinquent state” is not simply a behaviouristic standard: it implies a considerable improvement in the patient’s mental condition, *e.g.* an improvement in neurotic symptoms and/or in stability of character. Most delinquent cases treated fall into this group, and it has been decided to set an arbitrary period of five years’ freedom from delinquent behaviour as a criterion of cure for this group. Of the total of 28 discharged as improved in 1939, 13 were admitted in 1938, 3 in 1937, and 2 before 1937.

The “Unimproved” group includes only cases whose lack of response to treatment is due to intrinsic difficulties. The number in 1939 is high: possibly the necessity to “close” cases in August of that year accounts for this. With regard to the heading “Discharging self”: it is significant that the highest figure, viz. 20,

falls in 1937; of these 12 were pre-1937 cases, *i.e.* cases under treatment before the Clinic was opened. The number of uncooperative cases dropped substantially afterwards. The factors inducing non-cooperation are divisible into unconscious, conscious and environmental groups. Of the first group (unconscious resistance to treatment), psychological gain through illness and strong aggressive drives leading to lack of positive rapport with the physician are the best examples. One conscious factor may be described as "lacking awareness of the need for treatment". A neurotic or early psychotic case is usually well aware of his need for help, but a delinquent does not find it at all easy to grasp the connections between disordered conduct and mental health. For the matter of that he often is unaware that his conduct is disordered, although he may agree tranquilly with the view of society that it is "bad".

The environmental factors reinforcing "non-cooperation" are of two kinds. As in ordinary psychotherapeutic practice, there is a good deal of conscious and unconscious opposition to treatment on the part of parents, family and friends. On occasion this may be strong enough to make the patient discontinue attendance. Again, where the patient appears to have improved, an apparently natural reaction develops (not only in the patient or his friends but sometimes in the probation officer), *viz.* to be content with superficial signs of progress, and therefore to favour discontinuing treatment. Apart from all this patients who show signs of improvement have often to discontinue treatment owing to circumstances beyond their control, *e.g.* change of work or place of residence, extended hours of employment, etc. War conditions have inevitably aggravated this state of affairs. Incidentally, when a patient discharges himself, he may, nevertheless, have received sufficient treatment to ensure success, though we purposely avoid describing him as "improved" or "cured", since we have not done all we consider desirable or possible for his amelioration. Although this is a sound scientific practice, it does less than justice to the practical value of the Clinic's activities. Thus the "cured" and "improved" groups are judged on a combination of medical, psychotherapeutic and social standards. If sociological considerations alone were taken into account, *e.g.* if cases making no further appearances at Court were regarded as "improved", a considerable number of cases at present labelled "unimproved", "discharging self", etc., would be transferred to the "improved"

group. Where patients are known to have relapsed, they have been included under Relapses. The real number of relapses will not be known until the first five years' survey has been completed; but it is not anticipated that it will be very much greater than the figures given above. Many cases are recidivist in tendency, and the fact that a year or two's freedom from delinquency is achieved is often worthy of note. "Old cases re-opened" are either relapses or cases where treatment was not carried out originally, either because the delinquent refused it, or because it was not practicable at the time.

In many instances particularly where psychological observation or probationary treatment has been recommended, results are reviewed by the Director who may draw up a supplementary report to be sent to the Court. This involves a good deal of time and labour, but adds greatly to the efficiency of the subsequent disposal. Here again the liaison services of the Psychiatric Social Worker prove indispensable. She is able, for example, to convey to the Probation Officer many useful observations on the characterological handling of special cases. It is appropriate to add here that this additional work, *i.e.* supplementary reports and social interviews, is also useful in the case of relapses during treatment.

PART VII.—AFTER HISTORY

In delinquency work, more perhaps than in any other form of psychological endeavour, it is important to keep in touch with old patients for some years after treatment. A five years' follow-up is aimed at for statistical purposes. This applies in the main to cases given treatment, but it is worthy of note that even in the case of patients coming for "diagnosis only" the Clinic as a general rule does not lose sight of them for at least 12 months after referral. For a variety of reasons it is difficult to keep to these standards. Although in many cases the patients themselves make the first contact, in other instances it is inadvisable to "follow-up" too vigorously. The patient may feel sensitive about his past misdemeanours, or he may be afraid of "follow-up" contacts in case some relative or friend may "get to know". However, should a patient relapse the Clinic is likely to hear of it through the Court or the probation officer originally in charge of the case. During war-time, evacuation and change of location of employment makes "follow-up" a matter of extreme difficulty. Consequently the findings are not of

great statistical value. So far as can be ascertained, however, recidivism amongst those who have completed treatment is rare. Of the 102 cases referred to the Institute during 1941, up to December 31st, so far as we have been able to ascertain, nine only got into further trouble, two being patients who had received treatment here. One of the latter was an habitual drunkard, perpetually in and out of prison. Three were sent to approved schools and three received sentences of imprisonment. With regard to patients of previous years, ascertainment of their present position was more difficult; but of those who were treated at this Clinic only three are known to have been recharged. Two of these voluntarily returned to the Institute for a further period of psychotherapy. These facts permit some broad generalisations regarding the results of treatment at the Clinic. As was pointed out earlier, cases discharged as "improved" are clinically free from delinquent reactions, but cannot be regarded as cured unless their after-history is satisfactory. Since recidivism is rare, however, it is justifiable to add this group to the "cured" group when estimating the number of "satisfactory results" achieved by psychological means. It should be remembered, of course, that by no means all cases are offered psychological treatment, and that of those offered psychological treatment by no means all complete it. Nevertheless, a rough estimate of the results obtained at this Clinic can be arrived at by noting in any given year, first, the percentage of all cases that have been offered and have accepted treatment; and second, by observing what percentage of cases discharged having previously received psychological treatment (irrespective of whether they complete it or not), were considered to be "cured" or "improved". Thus of the new cases examined in 1937, 29.34 per cent. accepted psychological treatment. During the same year 53.84 per cent. of all cases discharged after having been given some psychological treatment were regarded as "cured" or "improved". The corresponding figures for 1938 are 26.51 per cent. and 58.93 per cent.; for 1939 30.91 per cent. and 49.42 per cent.; for 1940 32.46 and 20.75 per cent.; for 1941 38.32 and 15.55 per cent. The drop in the percentage of "cured" or "improved" from 1939 to 1941 inclusive is accounted for by the fact that a large number of cases were "closed", "suspended" or otherwise interrupted before treatment could be completed, and by the fact that owing to war-time shortage of staff we had to be content with short term treatment in almost all cases. Allowing a margin of error (*i.e.* recidivism), which in any case is

reduced by satisfactory results noted in the after history of cases discharged as "unimproved", and averaging out fluctuations due to the influence of war conditions, *the fact remains that an average of almost 40 per cent. of cases given psychological treatment at the Clinic may (even if they do not complete their treatment) be expected to become and remain non-delinquent as the result of that treatment.* In arriving at these rough estimates we have not followed the legitimate practice of estimating results only in those cases that have completed the prescribed course. If we were to exclude all cases which for one reason or another did not complete treatment, the percentage of satisfactory results would be almost too good to be true. To be on the safe side we have included *all* cases given treatment, whether the treatment was completed or not. This procedure is justified on two grounds: first, that, as has been noted, many cases whose treatment is discontinued, have nevertheless improved a good deal and second, that even cases whose treatment is interrupted after only a few sessions, have been subject to a new psychological situation and may therefore respond favourably. This is borne out by the fact that probation officers applying their "social techniques" without the reinforcement of clinical methods are able to record many successes in their handling of delinquents.

In estimating the number of "satisfactory" results, we do not leave out of account the fact that *spontaneous remission or resolution* of symptoms is observed in every variety of psychological disorder. For example, it has sometimes been estimated that 35 per cent. of certified schizophrenic cases remit spontaneously. In the case of psycho-neurotic patients the recorded percentage of spontaneous remission has varied between 7 per cent. and about 33 per cent. No doubt this factor of spontaneous remission operates also in delinquent cases. Most hospital authorities or, for the matter of that, general physicians are in the habit of crediting their therapeutic techniques with cures that might have occurred spontaneously. And until diagnostic methods are more delicate than they are at present it is no easy matter to recognise and eliminate these so-called "abortive" types. To be on the safe side, however, one should allow for an ample margin of error. But even if for the sake of argument we were to allow a 20 per cent. margin for spontaneous remission, the percentage of satisfactory results obtained from the psychological treatment of selected delinquents would stand at 32 per cent. This is a notable achievement, the sociological implications of which are difficult to over-estimate.

It should not be forgotten, however, that psychological treatment is usually, and often of necessity, combined with environmental "handling". In court cases this takes two forms. The probation officer (*a*) maintains some degree of supervisory contact and (*b*) frequently plays a part in smoothing over social difficulties, in finding suitable billets and in securing employment. By agreement with the court it is sometimes possible to vary the amount of probationary supervision to meet the psychotherapeutic needs of the case. In non-court cases a varying amount of environmental influence is brought to bear by club-leaders, hostel wardens and other social workers. Apart from all this the Clinic's *psychiatric social worker* plays an important part in organising suitable environmental conditions and in dealing with difficulties at home or in the school. She also acts as liaison officer between all the parties concerned. The distinguishing feature of the psychiatric social work carried out at the Clinic is that it is regulated and "dosed" in accordance with the psychological necessities of the *individual* case. These factors influence to a considerable extent the delinquent's state of positive rapport both with society and with the Clinic. Generally speaking the more effectively these factors are applied, the better are the results of treatment. It cannot therefore be claimed that the results described above are due *solely* to the psychological techniques employed. Nevertheless, allowing an ample margin for the effect of environmental handling, it is fair to say that one of the principal contentions of those who founded the Institute has been justified, viz., that delinquency cases of various types and ages are amenable to appropriate treatment.¹ Moreover, it has been proved up to the hilt that the problem of delinquency is a highly specialised problem, calling for special organisations (Institutes, Clinics, etc.), special forms of training and special techniques of treatment. In a word, delinquency work constitutes a new

¹ It does not come within the scope of this report to make comparisons between the results obtained by scientific methods of treatment and those following ordinary legal procedures. Accurate statistics are hard to obtain and in any case the data themselves do not permit of any legitimate comparison. The figures of the Prison Commissioners on the after histories of over 4000 persons committed to prison for *serious* ("finger-printable") first offences showed that after 8 years only 18 per cent. had been imprisoned a second time. It is scarcely necessary to point out that there is no basis of comparison between this group and the group dealt with by the Institute; also that the standard of "cure", viz. absence of a second sentence is, compared with the stringent standards adopted by the Institute, both clinically and socially inadequate. In any case the results obtained by the Institute were achieved under "ambulant" conditions: i.e. the individuals were, subject to a degree of probationary supervision, at liberty.

medico-psychological "speciality". It is important to emphasise this point since it is sometimes argued that the treatment of delinquents does *not* call for special organisations, that, for example, cases might just as well be referred to a Child Guidance Clinic or to any of the psychiatric outpatient departments that exist at general or mental hospitals. This is far from being the case. Actually, when the Institute was founded, some misgiving existed lest prospective patients would shrink from attending a public delinquency centre; and so, the name *Psychopathic Clinic* was adopted. The misgiving proved to be unfounded. Apart from the fact that the Court's "condition of attendance" is a compulsory one, it has proved possible to attain a very high standard of professional privacy and discretion, much more, in fact, than is usually possible at any Psychiatric Clinic where teaching classes are held. In any case, the main presumptions on which general psychological clinics are founded are that the patient comes of his own accord because he is "suffering", and that he wishes to become "well" again. This does not apply to the same degree in delinquency work. Further, the techniques employed, both individual and environmental, are definitely specialised, and are so closely dovetailed that it is impossible to get the optimum result without steady team work. No doubt good work can be done by individual therapists but only if they are prepared to act also as their own social workers. If, however, the policy of sending cases to general psychiatric centres is adopted, it is essential that these centres should organise special delinquency departments and staff them with specially trained teams.

PART VIII.—FUTURE DEVELOPMENTS

It would be impracticable, as well as unnecessary to examine every delinquent appearing before the Courts, but in view of the rather haphazard method of selecting cases before referral to the Clinic, it is extremely probable that the number of delinquents who could be improved by modern psychological and sociological methods is higher than is indicated by the above results; and it will be remembered that, as pointed out in the section on Disposal, the number actually treated for one reason or another falls far short of the number recommended for such treatment. Moreover, it has been shown that valuable advice concerning social adjustment, or the best form of life-routine for various character types, can be

given as the result of diagnostic examination or observation. The extent to which London Courts make use of the Institute has already been discussed, but it cannot be doubted that increased facilities would result in increased referrals. Probation Officers are naturally anxious that their cases should be diagnosed, and if necessary treated with a minimum delay. During the period when it was possible for the Institute to appoint a salaried Medical Registrar (all other medical appointments are honorary) the number of referrals increased substantially. A glance at the waiting lists over a number of years shows that it is already urgently necessary to increase the technical and administrative staff. Apart from this urgent requirement, there are six possible extensions of activity which would add greatly to the usefulness of the Institute. These are: (a) the provision of a suitable *Hostel* in London, where patients who are receiving treatment could reside and be suitably occupied, and (b) the organisation of an *Observation Centre* outside the London area where patients could be under skilled psychological observation pending a diagnostic report to the Court, and/or during short terms of treatment. (c) Since the treatment of delinquency calls for highly specialised methods, it is essential to develop a scheme of *staff-training*, whereby physicians who have already been thoroughly trained in the principles and practice of medical psychology and psychiatry can receive the additional training necessary for delinquency work. The training scheme should include also special courses for lay psycho-therapists and other non-medical staffs. (d) Since good treatment depends on good research methods, it is essential that the psychotherapeutic work of the Clinic should be backed by extensive and intensive *research* projects. (e) The organisation of *team conferences* to which the Probation Officer and if at all possible the Magistrate interested, could be present. Some experimental work has actually been done in this respect: for example, conferences have been arranged between our staff, the Court Magistrate, the Probation Officer and any other person interested (e.g. in one case the club leader with whom the boy was then living was invited). (f) Lastly, in addition to our existing courses for Probation Officers, the organisation of *seminars for Magistrates and Clerks of the Court*.¹

¹ It was thought that the war would seriously affect the Institute's non-clinical activities, but happily this has not been so. A great reduction in available Medical Staff made week-end lecture courses for doctors impossible, but with this exception the Institute's educational work has actually increased since 1939. When evening

All this requires money and, under existing conditions, involves extensive publicity work. In any case, although the Institute and Clinic owe their inception to the fore-thought and generosity of private individuals, they have now reached the stage when reliance on voluntary contributions limits their usefulness. It is a commonplace of social development that pioneer stages are left to the efforts of private individuals or institutions. Official bodies are naturally averse to embarking on new ventures until their immediate utility has been established. But since delinquency is essentially a social manifestation, society cannot fairly continue to delegate its responsibilities to private individuals. It may not be advisable for the Government or for local authorities themselves to provide psychotherapeutic and other medical services for delinquents, apart, of course, from those who are already in prisons. It is difficult enough for psychologists in a purely private professional capacity to secure successful results, and it is not to be expected that those who are called on to judge and condemn will be particularly successful in promoting therapeutic endeavour. However that may be, one of the most pressing problems with which the I.S.T.D. is confronted is not, as might be imagined, to overcome the difficulties inherent in the work, but to achieve a sound economic basis.

lectures became impracticable, work for the University of London's Diploma in Social Studies (for which the I.S.T.D. became a recognised centre in 1938) was organised at week-ends. An excellent average of attendances has been maintained, even during the worst periods of enemy action, and this in spite of the fact that many students live in Home County areas. The curriculum for the Diploma embraces "Social Psychology", "Social Structure", "Social Philosophy", and in the fourth year "Criminal Law and its Administration" and "The Freudian Theory of Delinquency". Supplementary, though separate, courses have also been arranged in response to a wide demand from students. Four introductory lectures on "Vocational Guidance" and courses on "The Development of Mind", "Anti-Social Behaviour: its Causes and Treatment", "An Introductory Psychological Course for Probation Officers", and "The Nature and Variety of Human Behaviour" have been given. Another educational development has been the arrangement of seminars for a specially selected group of advanced students actively engaged in social work (Probation Officers, Policewomen, Welfare Workers, etc.), in which their day-to-day case work is discussed with a psychiatrist, and difficulties examined and interpreted. Naturally intimate and confidential work of this nature must be confined to a small group, but the results are most encouraging. To meet the needs of members of the Institute and students outside London a lending library has been formed. By this means many who cannot attend lectures can undertake prescribed courses of reading.

XIII

REPORT ON THE WORK OF THE EXETER CHILD GUIDANCE CLINIC

By DR. R. N. CRAIG

EARLY in the year 1932 there was operating in Exeter an out-patient Clinic for Nervous Diseases. This Clinic primarily dealt with adults, though from time to time children were brought up on account of various psychological difficulties. Gradually the Clinic was used on a steadily increasing scale by various people interested in juvenile problems, so that in due course in the year 1935 it became necessary to split it into two parts, providing a separate session for children. Up to the year 1937 the Child Guidance work was done largely by myself with the help of certain Lay workers, but by the year 1938 it had attained sufficient proportions that this was no longer practicable, and the staff was accordingly enlarged to its present proportions and housed in a new building. Such, in brief, is the history of the development of the work in Exeter.

The material dealt with at the Child Guidance Clinic in Exeter is drawn from a very scattered field. The bulk of the cases come from the Exeter Education Committee (through the School Medical Officers), the Juvenile Courts, the Devon County Council, private schools, general practitioners, parents, social workers (particularly Probation Officers) and the clergy. From this list, it becomes clear that interest in the difficulties of children is widespread; and the fact that the source of supply is as varied as it is shows every indication of the awareness of problems of delinquency and problem difficulties in children and young people, and a desire to obtain access to and advice from those who are competently trained.

The present constitution of the staff working at the Exeter Child Guidance Clinic is as follows: a Medical Director, two psychiatrists, three psychologists, a home visitor whose duties are amplified from time to time by assistance from certain organisations who are able to help in giving reports on the home conditions in the more remote parts of the area covered by the Clinic, and an organising secretary. The latter is an extremely important part of

the team, for it is she who keeps the whole of the mechanism running smoothly and acts as liaison officer between the staff and parents and organisations dealing with the children from outside. It has been found that, with a team of this size, a sound conception of the problems on hand can be obtained. I would particularly stress a practical point that arises in connection with this, and that is the need for very careful selection of the personnel. It is unfortunately only too easy, and by no means uncommon, for workers in Child Guidance to work out their own difficulties through patients, which, whilst being of considerable assistance to the worker, has disastrous effects upon the child; further, the number of psychological extremists is not inconsiderable, and great care should be taken in avoiding such persons; and lastly, the personality of the worker himself is a very important point to take into account.

When a young person is brought to the Clinic a routine examination is carried out; and before describing the methods used it would perhaps be as well to detail what the examination is intended to discover. It is designed to ascertain in the first place the cause of the difficulties which have given rise to the disorganisation of behaviour, so that advice may be given to other people as to the best method of dealing with it; and, if necessary, leading out of that examination, we carry on with the treatment that may be needed. A certain constant routine is adopted and carried out with every child, unless some exceptional circumstance arises which prevents it being done. Every child receives a careful physical examination, the results of which are recorded on a separate sheet. Also, a full intelligence test is done, as well, so as to exclude as far as possible the presence of anything psychotic or any other more grave condition; and, lastly, the psychologist investigates the whole position. The results of these various examinations are recorded on separate sheets of paper and incorporated into one case sheet which is finally submitted to the Medical Director for his opinion and comments. Also, where possible, the home visitor goes to the houses and a report of the home conditions is obtained. Certain specimens of this routine are enclosed with this paper, as illustrations.

At the Exeter Child Guidance Clinic a certain classification of the cases is adopted. This comprises psychotics, psychoneurotics, constitutional inferiors, psychopaths, mental defectives, and cases of physical illness. It seems to work well, on the whole, and to

cover the vast majority of cases. Naturally, it not infrequently happens that cases ultimately prove to be mixed ones—that is to say, they display certain features of two types of illnesses. For instance, it is not at all uncommon to find a high grade or middle grade defective showing secondary psychoneurotic difficulties as a result of his primary defectiveness and of being pushed into a station in life beyond his mental capabilities. This classification is used throughout the whole work, and no different classification is used for delinquent or non-delinquent children, in that in this clinic it is felt that the use of these two terms is very undesirable, for certain reasons which will be dealt with more fully later on. The classification further helps by ensuring that the time of the workers is not absorbed in endeavouring to deal with material where treatment is limited by the patient's heavy constitutional limitations, and that the patients who are in emotional difficulties for whom so much can be done are given every chance of being adequately assisted.

In our opinion it is very important not only that an accurate diagnosis and classification of the cases should exist, but that an early effort should be made to allocate the cases to their proper grouping as soon as possible. But though this is desirable from a diagnostic point of view, there does appear to be a pitfall in it. All too frequently a case may receive its diagnosis and, having had its label placed upon it, if it falls within the more serious type of personality disorder there is an inclination to pass it over as being incapable of having anything further done for it. I think it by no means follows that because a case proves to have a psychotic trend or a definite intellectual impairment nothing can be done for it, as efforts should be made to create a set of circumstances within the patient's life to enable him to live as comfortably and efficiently as possible as far as his own well being is concerned as well as that of other people, within the limits of his constitutional difficulties.

The classification outlined above appears to cover most of the cases met with that have come into conflict with the community. Though in this respect I would stress that the services of the Clinic as a whole are used very much more in relationship to young people than to adult anti-social or criminal persons; and our experience with regard to such cases is that they tend to run along typical lines of psychopathic behaviour, and their behaviour is essentially dictated by psychopathic difficulties which tend to pro-

duce a constant pattern of response. This does not, of course, apply to cases of anti-social or criminal behaviour arising out of organic diseases, particularly encephalitis.

In our experience, encephalitis appears to bring about a severe disorganisation of behaviour in the adolescent or young adult victim; whereas in the older cases there appears to be little disorganisation of behaviour but, on the contrary, the sequelae of the disease show essentially neurological features. In the adolescent or young post-encephalitic, neurological signs and symptoms are the exception rather than the rule where there is gross disorganisation of behaviour. It appears to us that this disease is all too often overlooked, in that the initial attack is frequently overlooked as it so closely resembles "influenza", particularly in the adolescent where, as I have stressed, there is frequently an almost complete absence of neurological signs. The disorganisation, however, arising from this disease is, in our experience, profound. Another organic condition which we have been struck by in relationship to the severity of the disorganisation of behaviour to which it gives rise, is that of hypoglycaemia. During the last ten years, we have had several cases in young people whose behaviour showed a periodical disorganisation of an extreme character, who completely cleared up on being given steady doses of glucose. This is a condition which can be frequently overlooked. Further, there is a third condition along the physical plane which is often misunderstood, and that is, a masked epilepsy. It is our experience that certain heavy disorganisation of conduct which arises in young people who show few emotional difficulties and in whom there is no underlying constitutional factor, is due to this masked epilepsy. I am enclosing three case sheets illustrative of these types.

In Exeter the Juvenile Court has made very extensive use of the services of the Clinic, and perhaps it is of interest to note the relationship of the Court to the Clinic. Earlier in this paper I pointed out that the Court began by referring desultory cases of children for opinion, and asked for suggestions with regard to treatment. Our reports which were sent for the use of the Magistrates apparently proved sufficiently helpful that a period was entered upon when virtually every child who had come before the Court was first referred to the Clinic for a report. The present position, however, is that the Court now refers certain of the more difficult cases to the Clinic for assistance. It will at once become clear that

there has been a considerable variation of procedure between the Court and the Clinic, and in order to understand the reasons for this I should perhaps mention that for a considerable time the Clinic was (and even now to a large extent is) very largely supported by purely private financial sources, and until recently it had no official relationship to the Education Authorities, and certain practical difficulties arose as the result of this. For instance, if a child was referred by the Court to the Clinic, not only for a report, but for treatment, certain marks were lost at the school when the child attended the Clinic, and though steps were being taken to deal with factors involving the child's whole personality and involving its education, nevertheless the school was penalised as the result. Fortunately, however, thanks to the cooperation of the Medical Officer of Health for the City, and to the Secretary for Education, these difficulties have been overcome, and there is now no trouble in giving the young person the assistance at the Clinic which frequently enables him to get considerably more advantage and benefit out of his education than he could hope to have got without it. During the period when all children were referred to the Clinic for a report, certain other practical difficulties arose. At the time the child was brought to the Clinic it had not actually appeared before the Court, but it became part of the routine to have the child examined and a report given so that the Magistrates might have all the material available to help them to arrive at an adequate decision. The Clinic, not unnaturally, assumed that the child had done that with which it was charged, but in due course it was pointed out by one of the members of the Bench, who happened to be a member of the legal profession, that this assumed the child to be guilty before it was tried, a position which was quite untenable to the Law and clearly enabled any defending solicitor to take grave exception to the procedure. In consequence of this the proceedings were modified and the child now appears before the Juvenile Court where the question as to whether it is guilty or otherwise is settled first, and it is then referred to the Clinic for an opinion and report. This report is then sent to the Court, and the Court decides what steps they will take from a legal point of view—that is, whether the child shall be placed on probation—and if treatment has been recommended the case is referred to the Medical Officer of Health to decide whether such shall be carried out or not, as if treatment is decided upon it becomes a matter for the Education Authorities and the consent of

the Medical Officer of Health must be obtained before the Education Authorities will accept responsibility for it.

On the whole, I think this procedure works quite well, and the only question that arises in this paper is whether it is desirable to obtain a report from the Child Guidance Clinic on every child or only on certain selected cases. For my own part, though it adds very heavily and materially to the work of the Clinic, I feel that, when practicable, it is better to examine every case. It is true that some time may be wasted over some quite trivial childish offence, but on the other hand, because a child is apprehended for its first detected anti-social act it by no means follows that it is the first time it has done it. On the contrary, it frequently transpires that the stealing has been going on for a number of years undetected. If, therefore, such a case is dealt with as being a first and isolated case of stealing, and simple probation is used, an opportunity of dealing with the motives that promoted the acts of steady stealing is lost, and the treatment which is necessary is delayed until there is a further outbreak. Again, the anti-social act may have arisen unexpectedly and inexplicably and as such been dealt with by simple probation, whereas the true cause of the condition might easily have been an organic one, which a routine examination would have revealed. I unhesitatingly feel that a routine examination of those who are being dealt with in any Juvenile Court is desirable, both for the above reasons and because there would appear to be a time in the life of so many criminals and anti-social persons when they could have been helped, but with the passage of time the anti-social trend becomes more deeply engrained, ultimately assuming an integral part of the personality almost amounting to a state of conditioned reflex.

Further, the more serious anti-social acts, particularly perhaps those along the sexual plane which are therefore more serious from the point of view of the community, are by no means the most grave and difficult to correct. For example, my Clinic has handled at various times some fifty cases of exposure, and so far not one of these cases have relapsed. It is, of course, well recognised psychologically that punishment for such an act as this, far from having the slightest corrective value only makes the difficulties infinitely worse. Again, from an economic point of view it would appear that the cost to the community of providing adequate investigation and treatment early on, of a young person's anti-social trend, would compare very favourably with the cost to the community

of providing semi-permanent accommodation and attention for long periods in a patient's life, apart from the fact that such early treatment may well convert what may be regarded as a permanent liability to the community into an asset.

Thus, from a social, personal and economic point of view, it seems to me that a routine examination of every young person charged with an anti-social act is desirable, providing that adequate means for carrying this out can be obtained.

Certain obvious improvements could be suggested. (1) But for the intervention of the war, the Exeter Child Guidance Clinic would have acquired—again through private enterprise—a Hostel to which cases could go for direct observation and where they would be removed from unsuitable home environments. In my opinion such a place is almost imperative, in that the work of unravelling really difficult psychological problems, which can only be done with the young person's assistance, is frequently made a hundredfold more difficult by the verbal and active aggressiveness of the parents who often are in heavy psychological difficulties themselves, with the result that the child is almost inaccessible for the first two or three interviews. It is true that Remand Homes are provided, but I do not think anything like sufficient precautions are taken with regard to the careful choice of the personnel. This Clinic has had some illuminating experience in this respect, which leaves very much to be desired. In one case, the officer in charge of the Remand Home held the view that all problem difficulties could be read by studying the palm of the hand of the delinquent, and could be corrected by dealing manually with his seat! The results obtained from this particular Remand Home were not encouraging! (2) I should further suggest it is very desirable to extend facilities for adolescents who are having their psychological difficulties dealt with to live and lead a useful, organised, active life under skilled supervision. It is often advisable for a case to be treated two or three times a week, which leaves ample time to be filled in and allows for an individual to be gradually trained in an occupation which would enable him to become a useful citizen, or to actually continue to earn his living under sheltered, settled, and constant conditions during this treatment, the treatment being carried out when he has finished work or at certain specifically allocated times. (3) Lastly, it would appear desirable to have as a member of the Child Guidance Clinic a person adequately trained in and thoroughly familiar with the

methods of vocational guidance, in order that when an adolescent's difficulties have been dealt with he can be fitted into a station in life consistent with his physical and personality make up. At one period in the history of this Clinic a very highly trained worker was available, and her contributions and results were of the greatest possible assistance towards the work of the Clinic.

INDEX

- Abbott, E, 237, 238
 "Absolute liability", xi
 Accidents, neuroses attributed to, 122, 123-133
Actus reus, ix
 Adler, Alfred, 232, 238
 Adolescent offenders, statistical study of, 150-55
 Affections, thwarted, and delinquency, 5-6, 81, 82, 83, 85, 86-7
 After-care, offenders mentally affected, xxii
 After-care system, xxi
 Age and causation of crime, 154-5
 Aichhorn, A., 82, 85, 92
 Alcohol, 163; its action on the body, 164-8
 Alcoholic dementia, 169, 170-71
 Alcoholic insanity, 169-170
 Alcoholism, 6, 42, 43, 163-4; acute, 168-9; chronic, 169; mental disorders caused by, 14, 43, 169-172
 and criminal behaviour, 163-176, 277;
 and criminal responsibility, 173-5; and sexual offences, 188-9, 193, 194
 Alness, Lord, judgement of, xiv, 61-2, 107, 111, 112
 Alverstone, Lord, 172
 America, mental deficiency in, 100; anthropological study of criminals in, 147, 148-150, 151, 154
American Criminal, The (Hooton), 147, 148, 149-150, 151
 Andrews, x
 Amnesia, 88, 132; alcoholism and, 170, 171-2; hysterical, 172; war experiences and, 245-9, 252; feigned, 252
Annual Report of the Prison Commissioners, The, 1938, 183, 205, 206
 Anonymous letters, 189, 259
 Ansell, C., 238
 Anxiety psychoneurosis, 73, 128-130, 278
 Approved School system, 119, 120, 151, 284, 285-7
 Argelander, A., 231, 238
 Armstrong, Clairette P., 154, 160
 Army, the: life in, 240-44, 245; special meaning of "crime" in, 240, 254; mental defectives in, 253-4, 256; criminal offences in military service, 255-268
 Arson, 86-7, 200
 Arteriosclerotic brain disease, 44, 193
 Arthur, G., 231, 238
 Aschaffenburg, G., 159, 160
 Assault, mental disorders and manic-depressive psychosis and, 4, 12, 14, 16-17, 18; schizophrenia, 19, 21, 22, 25-6; paranoia, 29, 30-31; brain disease, 44; epilepsy, 47, 48; psychopathic constitution and, 111-112; alcoholism, 167-8, 169, 172, 173; sadistic, 200
 indecent assault, 180, 181, 183, 189, 190
 Asthenic type, 158, 159, 208, 213
 Athletic type, 158, 159
 Atkins, Lord, xiii, 258
 Autoeroticism, 185, 195, 196
 Automatism, epileptic, 47, 48, 49

 Baker, H. J., 237, 238
 Beard, x, 123
 Beccaria, Cesare, 141
 Behaviour problems, 275, 276, 277, 278, 287, 288; birth-order and, 234-6
 Benjamin, Frank, 154
 Bentham, Jeremy, 141, 177, 178, 184, 206
 Berry, R. J. A., 150, 161
 Bestiality, 179, 180, 186, 187, 191, 203
 Bevin, Ernest, 125
 "Beyond Control", 275, 276, 279, 288
 Bigamy, 181, 183
 Binet-Simon test, 225, 281
 Birth-order, and delinquency, 227-237; and physical characteristics, 229-30; and psychological characteristics, 230-232; and character personality traits, 232-4; and behaviour disorders, 234-6
 Black-outs, mental, 3
 Blacker, C. P., 91
 Blatz, W. E., 237, 238
 Blinkov, S., 159, 161
 Bloch, Iwan, 198, 206
 Board of Control, The, 104
 Boehmer, Kurt, 159, 161
 Bohannon, E. W., 232, 238
 Borstal Institutions, xxi, xxii
 Borstal System, xxi
 Borstal treatment, 119, 120, 151
 Bott, H., 237, 238
 Brain disease, effects of, 13, 40, 41, 42, 44, 168, 193, 209

- Brain injury, effects of, 13, 123-7, 168, 193
- Brain structure and character, 142
- Bramwell, Lord, 54
- "Breaches of the peace", 172
- Breckinridge, S. P., 237, 238
- Brend, W. A., 124-25, 133, 140
- British Medical Association, 139, 140, 164
- Bronner, A., 83, 214
- Brougham, Lord, 54, 55
- Brown, William, 219
- Buchner, L. W. G., 150, 161
- Burt, Cyril, viii, 3, 95, 99, 153, 161, 228, 236, 237, 238
- Burt, William, 55
- Busemann, A., 233, 234, 238
- Capital Punishment Report (1930), xiii
- Carlier, 153
- Carus, C. G., 143, 161
- "Catathymic crisis", 89, 106
- Cathcart, E. P., 151
- Cattell, J. McK., 230, 238
- Cecil, Lord David, 74
- Chalmers, A. K., 151
- Chapman, J. C., 231, 238
- Character-traits in juvenile delinquents, 215-216; I.S.T.D. statistics of character reaction cases, 277; diagnosis and treatment, 278, 288
- Child Guidance Clinics, 219, 235, 274, 287, 297; Exeter Clinic, 300-307
- Childhood, genesis of neuroses in, 77, 79-80, 81, 83, 84-5, 87, 89, 124, 214-15; effect of thwarted affections in, 5-6, 81, 82, 83, 85, 86-7; of parent-child relationships in, 80, 81, 83, 84-5, 214-15, 218, 220, 227; of disabilities in, 208-10; and homosexuality, 84-5, 87; and incendiarism, 86-7, 89; and murder, 89-90; and sexual offences, 198, 199
- Children and Young Persons Acts, 204-5
- Christ's Hospital, Horsham, 153
- Clarke, Vans, 145
- Cleland, Paul, 154, 161
- Clinic for Juvenile Delinquents, Chicago, 7
- Cocainism, 13
- Coleman, S. M., 206
- Combe, G., 142, 161
- Committee on Insanity and Crime (1924), xiii, 56-7, 58, 59, 65-6, 69, 70, 71
- Committee on Sexual Offences against Young Persons (1926), xviii
- Committee on the Working of Penal Servitude Acts (1879), xx
- Common Law, ix, x, xi, xii
- Compensation cases: psychopathology and, 122, 123-7, 128-140; annual number of, 135
- Compensation motive in delinquency, 83, 84, 85, 86
- Congress of Criminal Anthropology, Turin (1906), 143
- "Compulsions", 80
- Concussion, effects of, 3, 246
- Conscience, 77, 79, 213, 214
- Conscientious objectors, 243-4, 260
- Conversion hysteria, 278
- Convicts: mental deficiency among, 94, 145; classification of defectives among, 98, 99-100; physical characteristics of, 145-159; after-history of, 296 *n.*
- Copenhagen, prostitution in, 191
- Courts of law, their attitude to psychological treatment, 203-4, 283-4, 292, 293, 296, 297, 298; Court psychiatrists suggested, 119, 120. *See* Law and medicine
- Cowardice, fear and, 251
- Cranial formation and criminality, 142, 143
- Crime: types of, classified, 2-7; epilepsy and, 9, 48, 55, 144, 158; relatively rare in paranoiac states, 30-31; psychopathic constitution and, 43, 105-121; modes of genesis and functions of criminal acts, 82-92; expression of desire for punishment, 85; mental deficiency and, 93-104; physical factors and, 141-160; sense of guilt and, 222-3; birth-order and, 236-7; in military service, 240, 254, 255-268; sex and age distribution, 273-6
- Crime and the Man* (Hooton), (), xxi, 148-49, 150
- Criminal Code of Tasmania (1927), xiii
- Criminal Justice Bill, (1938), xxi, 204, 205
- Criminal legislation, divorced from the essential findings, xv
- Criminal Lunatics Act, 1800, 63
- Criminal responsibility, (Trials) Bill, Debate in the House of Lords, xiii; psychoses and, 8-71, 107-9; epilepsy and, 47, 48, 49; the McNaghten rules, 65, 66, 69, 70; mental deficiency and, 103-4; alcoholism and, 173-5; mental disease and, in military life, 258-9

- Cycloid type, 116, 257
 Cyclothymic temperament, 158, 159
- Dalbiez, R., 91, 92
 Davies, David, case of, 54-5
 Dayton, N. A., 230, 231, 238
 Deafness and delinquency, 152, 209
 Decker, F. J., 237, 238
 Defence mechanism, mental, 19, 77, 80; delinquent acts as, 84, 85, 86; war experiences and, 245-54
 Delinquency, types of, 2-7, 228; physical condition and, 143, 150-55; diagnosis and treatment of, 269-299. *See* Juvenile delinquency
 "Delinquent gangs", 220-221
 Delirium tremens, 40, 41, 169, 170, 171
 Delusions, 10, 17, 20, 21, 26-34, 34, 35-9, 52, 75, 171, 188; of grandeur, 42, 43
 Dementia, 11, 19, 20, 21, 23, 34, 41, 43, 47, 52; alcoholic, 169, 170-71
 Dementia praecox, 18, 235
 Depression, 4, 9, 10, 13, 41, 44, 50, 243, 244
 Dixon, Hepworth, 145
 Doe, Judge, 57
 Dreams, 184, 194
 Drug addiction, 43, 44, 193
 "Drunk and disorderly", "drunk and incapable", 168, 172, 173
 Drunkenness, 164, 166, 167, 168; the law and, 173-6
 Dual personality, 246
 Du Cane, Sir Edmund, xx
 Duckworth, W. L. H., 153, 155, 161
 Dysplastic type, 158, 159
- East, W. Norwood, 31, 48, 72, 92, 94, 98, 101, 161, 175, 206
 Ecclesiastical laws, xi
 Education Act, 1921, 95
 Egotism, 77, 83
 Electric convulsion therapy, 3
 Ellis, Havelock, 145, 161, 198, 206, 230, 238
 Emotional instability: and sex crime, 190; in military life, 253, 257-8, 259
Encephalitis lethargica, 2, 3, 44, 209, 218, 284, 303
 Endocrine imbalance, 160, 210, 215, 284
English Convict, The (Goring), 93, 146-7, 148
 Environment, influence of, 4, 5, 6, 96, 124, 125, 155, 156, 157; on physique of offenders, 151-2; and sexual perversion, 187, 192, 193, 194, 198, 199; and juvenile delinquency, 215, 216, 218, 219, 220, 221-2, 223-4, 227, 228, 229, 236; and behaviour problems, 276, 281; and psychological treatment, 286, 287, 292
 Epilepsy and criminal behaviour, 3, 42, 46-9, 144, 138, 189; and juvenile delinquency, 209, 210, 284, 303; and criminal responsibility, 9, 55; alcohol and, 168, 171; danger from, in war, 252; amnesia in, 246, 252; feigned, 252
 Erichsen, Sir J. E., 123
 Escape motive: in alcoholism, 6; and delinquency, 78, 83, 85, 86; in war neuroses, 78, 81, 245-7
 Exeter Child Guidance Clinic, Report on, 300-307
 Exhibitionism, 186, 187, 195-7. *See* Exposure
 Exposure, indecent, 14, 23-4, 44-5, 181, 183, 186, 187, 195-7, 305
- Facial expression and character, 145-6
 Fear, 5; an obstacle to justice, 106; morbid fears, 73, 74-5, 76, 80, 128; in war, normal and abnormal, 249-52
 Feeble-minded, the, 4; definition of, 95, 97, 99; and crime, 94, 98, 99, 102-3; number of, among convicts, 94, 98, 99, 101; intelligence standard of, 98; as juvenile delinquents, 226
 Fenichel, O., 92
 Fenton, N., 232, 233, 238
 Fetishism, 200, 202
 Feversham, Earl of, Committee presided over by, xix
 Field Force Sociology, 219
 Fitness to plead, question of, 102-3
 Fortes, Dr., 227, 228
 Fox, George, 113
 Frank, B., 161
 Frassetto, Fabio, 150, 161
 Freud, Sigmund, 27, 124, 198, 199, 206, 220
 Friedjung, 233
 Friend, G. E., 153, 161
 Fugues, 74
 Functional nervous disorders after injury, 122-140; causation, 123-7; phobias, 127-8; anxiety neurosis, 128-30; hysteria, 130-31; neurasthenia, 131; post-concussional syndrome, 132-3; psychoses, 133; mental deficiency, 133-4; treatment of, 134-40

- Gall, Francis Joseph, 142, 143, 145
 Galton, Sir Francis, 152, 161, 230, 238
 Gangs, delinquent, 220-21
 General paralysis of the insane, 40, 41, 188
 Germany: mental deficiency in, 100; observations on convicts in, 159
 Gillespie, R. D., 63, 92, 133
 Gladstone Committee (1895), xx
 Glover, E., 27, 51
 Glueck, B., 92
 Goddard, H., 225
 Godin, 152, 161
 Goodenough, F. L., 232, 234, 235, 238
 Goring, C., 93, 102, 145, 146, 147, 148, 151, 161, 236
 Gray, 150
 Griffiths, H. E., 138, 140
 Grimberg, L., 238
 Guilt, sense of, its effects, 10, 83, 84, 109, 213, 214, 222
- Habitual drunkards, prolonged detention of, xiv
 Habitual offenders, xx
 Hadfield, James, case of, 60
 Hall, Stanley, 232
 Hallucinations, 4, 20, 21, 22, 26, 75, 188; absent in paranoia, 27, 34; common in paraphrenia, 34; in delirium, 41, 170
 Hamlet type of murder, 89-90
 Handy, L. M., 157, 162
 Head, Sir Henry, 142
 Healy, William, 7, 83, 84, 92, 153, 161, 214, 228, 229, 237, 238
 Hebephrenia, 20
 Henderson, D. K., 63, 92, 133
 Hentig, Hans von, 179, 206
 Heredity: and crime, 4, 147, 148, 155, 156-8; and mental abnormality, 10, 13, 18, 96; and homosexuality, 193; and juvenile delinquency, 211, 218, 224, 225, 227
 Heron, D., 234, 239
 Hersch, 226
 Heterosexuality, 190, 194
 Hill, A. S., 237, 238
 Hirschfeld, M., 198, 206
 "Histrionic personality", 74
 Hogben, L. T., 227, 239
 Holmes, S. J., 228, 229, 239
 Homburger, A., 232, 233, 239
 Homosexuality, 84-5, 87, 113, 114, 178, 186, 187, 191-5, 200; unconscious, and paranoia, 27-8; judicial attitude towards, 84; in women, 195
 Hooton, E. A., 147, 148, 149, 150, 151, 161
 Hormonotherapy, 160
 Hsiao, H. H., 228, 229, 230, 231, 239
 Hubert, W. H. de B., 92, 185, 193, 194, 195, 196, 199, 200, 203
 Hughes, C., 151
 Hulbert, Harold S., 180, 206
 Hypnosis, treatment by, 246, 247, 248, 287
 Hypochondriacal delusions, 17, 20
 Hypoglycaemia, effects of, 3, 303
 Hypomania, 11, 12-14
 Hysteria, 51, 73-4, 87-8, 189, 278; ambiguous significance of hysterical signs and symptoms, 87-92; following injury, 130-31
 Hysterical amnesia, 172
 Hysterical paralysis, 51, 73, 88, 130, 249
- Idiocy, 4. *See* Idiots
 Idiopathic epilepsy, 46
 Idiots: definition of, 95, 96-7; intelligence standard of, 98; and criminal responsibility, 107
 Imbeciles, 98-9, 102; definition of, 95, 97; intelligence standard of, 98; among convicts, 98-9; and criminal responsibility, 107
 Imbecility, 4; birth-order and, 230
 Imprisonment, a mechanical cumulation of sentences, xvii
 Inadequate psychopathic types, 116-18
 Incendiarism in children, 86-7
 Incest, 179, 180, 183, 190
 Indecent assaults, 180, 181, 183, 189, 204
 Indecent behaviour, action of alcohol and, 165, 171
 Indecent exposure, 14, 23-4, 44-5, 181, 183, 186, 187, 195-7, 305
 Indecent offences, against young persons, xvii
 Indeterminate sentence, value of, 112, 120
 Inebriates Act, 1898, 175
 Inferiority, feeling of, 81, 83, 242, 252
 Inglis, Lord Justice Clerk, 60
 "Insane", the term, 50, 51
 Insanity, 50, 69, 96; epilepsy and, 48, 49; and criminal responsibility, 54, 69, 103, 174; the McNaghten rules, 54, 56, 57, 158, 159; tests of, 57; and uncontrollable impulse, 69; alcoholic, 168, 169-72, 174; birth-order and, 235

- Institute for Juvenile Research, Chicago, 231, 234, 235
 Institute for Mental Defectives, xiii
 Institute for the Scientific Study of Delinquency, 121, 269-99
 Intelligence: and juvenile delinquency, 211, 212, 220, 225, 226, 227, 228, 231, 282; birth-order and, 228, 230-32; standardised scales of, 97
 Intelligence Quotient, 97, 98; in juvenile delinquents, 211, 212, 220, 231, 282; and psychological treatment, 288
 Intelligence tests, 4, 97, 225, 226, 230, 231, 301; used by I.S.T.D., 281-2
 Intoxication, 166, 167-8, 169, 172; definition of, 164; and sex offences, 188-9, 194, 196
 Involutional melancholia, 14, 17-18, 188
- Jackson, R. M., xviii
 Jaensch, E. R., 213
 James, Miss I. M., 269 *n.*
 Jenkins, P. L., 228, 230, 231, 234, 235, 239
 Johnson, Samuel, 75
 Jones, H. E., 228, 229, 231, 232, 233, 235, 239
 Jung, Carl Gustave, 124
 Juvenile Courts, 272, 276, 303-4
 Juvenile delinquency: which objective criminal policy must attack, xix; physical defects and, 152, 289-90; epilepsy and, 209, 210, 284, 303; intelligence and, 211, 212, 220, 225, 226, 231, 282; inborn and acquired factors in, 218-227; birth-order and, 227-237; I.S.T.D. statistics, 273-6; in war-time, 274; work of Exeter Child Guidance Clinic, 300-07
- Karpman, B., 72, 82, 85, 92
 Katatonia, 20-21
 Kelly, T. L., 153, 161
 Kemp, Tage, 191, 206
 Kenyon, Lord, 60
 Kinberg, Olaf, 159, 161
 Kirchwey, G. W., 161
 Kleptomania, 278, 279
 Koch, J. L. A., 108
 Korsakov's psychosis, 43, 169, 170
 Kranz, Heinrich, 157, 161
 Kretschmer, E., 158, 159, 161, 213
- Lamb, Lady Caroline, 74
 Landecker, Werner S., 159, 161
- Lange, Johannes, 156, 157, 161, 225
 Langfeldt, Gabriel, 150, 161
 Lauvergne, 143, 162
 Law and medicine, their relations on questions of mental abnormality and crime, 1-2, 5, 7, 105, 107-9, 180; mental experts consulted by the Courts, 16, 60-61, 65, 102-3, 104, 204, 303-5; need for further collaboration between Courts and psychiatrists, 90-92, 119-21, 203, 204, 205; the problem of criminal responsibility, 56-71, 103-4, 107-9; compensation cases, 122, 123, 125, 129; the treatment of sexual offenders, 203-6; moral judgments and legal judgments, 222-3; cases referred to psychological clinics, 270-277, 282-3, 284-7, 288-9
 Lazarsfeld, Sofie, 195, 206
 Leahy, A. M., 233, 234, 235, 238
 Lefthandedness and delinquency, 209
 Lentz, T., 231, 239
 Leptosomes, 150, 158, 159
 Levy, J., 235, 236, 239
 Lewin, Kurt, 219
 Lewis, Aubrey, 75, 92, 160, 162
 Lombroso, C., 143, 144, 146, 147, 151, 162, 208
 Lump sum settlements in compensation cases, 129, 131, 137-8
 Lunacy Acts (1890), 94 *n.*, 203, 205
- Macaulay, Lord, 113
 MacCalman, D. R., 140
 MacCurdy, H. L., 154, 162
 MacDonell, Sir John, 105-06
 McDougall, W., 198, 206
 McNaghten Rules, the, viii, xiii, 54, 56, 57, 58, 59, 65, 66, 69, 70, 103, 158, 159
 Malaria, treatment of general paralysis by, 46
 Malinger, 123, 129, 135, 136, 139, 252, 254, 259
 Mania, 9, 10, 11-17, 53, 66
 Manic-depressive psychosis, 8, 9-17, 50, 188; and criminal responsibility, 56; constitution types, 158
 Mannheim, Hermann, 204, 206
 Mapother, E., 160, 162
 Masochism, 187, 194, 197-202
 Maudsley, Henry, 59, 169
 May, 133
 Mayer, 133
 Mechanical aptitude and juvenile delinquency, 226

- Mechanisms, mental, 9, 19, 26, 51
 Medical Research Council, 269
 Melancholia, 9, 10-11, 14, 15, 19, 56, 67; uncontrollable impulse in, 66-8; involuntional, 14, 17-18, 188
 Meningitis and delinquency, 209, 210, 218
Mens rea, viii, xii
 Mental defectives, 158, 302; numbers of, 93; procedure for treatment of criminal, 104; and alcohol, 168, 169; in military life, 253-4, 257, 258-9; danger from, in war, 254, 256; I.S.T.D. statistics of, 277, 284; and intelligence tests, 281
 Mental deficiency: and crime, 2, 3-4, 93-104, 107, 158; definitions and types of, 94-100, 101, 103; intelligence standards of, 98, 281; injury and, 133-4; birth-order and, 230-31
 Mental Deficiency Acts, (1913 and 1927), xiii, 93, 94, 95, 96, 99, 100, 101, 104, 145, 203, 205, 212
 Mental Deficiency Committee Report (1929), viii, xxii, 93, 98
 Mental disease, 50, 51, 69; and criminal responsibility, 69, 258-9
 Mental illness, 51, 52, 53
 "Mental Ratio", 97
 Mental tests, 225, 226
 Mezger, E., 158, 162
 Military life: reaction to, and criminal behaviour, 240-68; escape motive in certain neuroses in, 78, 81, 245-7
 Ministry of Pensions, 137
 Mongolism, 230, 232
 Moral defectives, 96, 99, 100, 103; among convicts, 98, 99-100; and criminal responsibility, 103
 Moral imbecile, 144
 Morellet, Abbé, 141
 Moreno, 219
 "Morons", 100
 Morphinism, 43
 Mortality and birth-order, 230, 236, 237
 "Multiple personality", 74
 Munich crisis, 1938, 242, 271
 Murder, 90, 91, 155; psychoses resulting in, 12, 15, 24-6, 31, 37, 43, 48, 89; insanity and criminal responsibility in, 61-2, 64-5, 66-7, 107, 111, 112; psychiatric interpretation of, 90-91; psychopathic constitution and, 110, 111-3; of sexual character, 188, 189, 200
 Myxoedema, 40
 Narcosis, treatment by, 246
 National Institute of Industrial Psychology, The, 282 *n.*, 287, 289
 Nervous breakdown, 9
 Nervous disorders resulting from injury, and compensation cases, 122-40
 Neter, 233
 Neurasthenia, 9, 73, 123, 124, 125, 131
 Neuroses, the, 50; treatment of neuroses after injury, 134-9
 Neurosis, 6, 8, 82; development of, 6-7; "shock" and, 124
 New Prison Rules (1843), xx
 New York City Children's Court, 154
 New Jersey State Reformatory, 154
 Newman, Cardinal, 179, 206
 Norcross, C., 137, 140
 Oberndorf, C. P., 236, 239
 Obsessional psychoneurosis, 73, 74, 80, 278; and sexual crime, 190
 Oedipus complex, 87-8, 220
 Only children, character traits of, 232-4, 235, 236, 237
 Oppenheim, 123
 Organic character-traits, 25
 Organic reaction types of mental illness, 40-46
 Organotherapy, 160
 Osler, Sir William, 125, 140
 Pailthorpe, Grace W., 269
 Paranoia, 19, 26-34, 52, 56
 Paranoid reaction types of schizophrenia, 26-39
 Paranoid types of schizophrenia, 21-26
 Paraphrenia, 34-9
 Parent-child relationships and genesis of delinquency, 22, 80, 81, 83, 84-5, 214-15, 218, 220, 227
 Parkhurst prison, 145
 Parmelee, 144
 Partial responsibility, xv; Scottish doctrine of, 61-2, 63, 107-9, 111, 112
 Passive or inadequate psychopathic types, 116-18
 Paton, x
 Pearson, Karl, 146, 147, 228, 229, 230, 234, 236, 239
 Penology, schools of, 141-2
 Penrose, L. S., 96, 101
 Penrose-Raven matrix test, 225
 Pentonville prison, 145, 148

- Performance Tests, 281-2
- Persecutory delusions, 4, 20, 27, 28, 29, 30, 32-4, 35-6, 44
- Personal Injuries (Emergency Provisions) Act, 132
- Personality of the offender, information relating to, xviii
- Phobias, 80; after accidents, 127-8
- Phrenology, 142
- Physical defects and juvenile delinquency, 152, 289-90
- Pina, Luis de, 150, 162
- Portland prison, 145
- Post-concussional syndrome, 132-3
- Prichard, J. C., 107, 108
- Prison system, to provide appropriate treatment for mentally abnormal, xx
- Probation Officers, xxi, 271, 272, 274, 285, 287, 293, 296, 298
- Probation system, xxi
- Procurator, 181, 183
- Projection mechanism and delusions, 19, 26, 27, 28, 78
- Prostate troubles and sexual offences, 189
- Prostitution, 178, 181, 183, 191, 213
- Proust, Marcel, 114
- Psychiatric Social Worker, 219-20, 280, 282, 287, 293, 294
- Psychiatrist, the: and Court proceedings, 110, 119, 120, 180; in I.S.T.D. work, 280, 281
- Psychiatry, and treatment of sexual offences, 114-15
- Psychoanalysis, treatment by, 246, 247, 287
- "Psychological observation", 287-8
- Psychological treatment: of psychoneurotics, 6-7; investigation desirable in military offences, 258, 259; and delinquency, 270, 271, 272, 284-99; at I.S.T.D., 287-90; results, 290-93; after-history, 293-7
- Psychoneurosis: meaning of, 72-7; types of, 72-5; and criminal behaviour, 72-92; spontaneous remission in, 295
- Psychoneurotic character-traits, 216
- Psychoneurotic delinquency, 2, 6-7, 72-92; I.S.T.D. statistics, 277, 284; diagnosis of, 278; response to treatment, 288
- "Psychopath", the term, 74, 108
- "Psychopathic Clinic", 297
- Psychopathic constitution, 74; and criminal behaviour, 105-121; clinical description, 108; and criminal responsibility, 107-9; varying types of, 109; and suicide, 109-10; and murder, 107, 108, 111-13; and sexual offences, 113-15, 190-203; "psychopathic character" group, 278-9; I.S.T.D. statistics, 284
- Psychopathology, development of, 123, 217, 227
- Psychoses, 3, 4, 8-49, 52, 53, 302; and criminal responsibility, 50-71; after injury, 124, 133; and sexual offences, 203, 204, 205; I.S.T.D. statistics, 277, 284; diagnosis of, in juvenile delinquents, 279; treatment of, 292
- Psychotherapy, 129, 131, 140, 216, 283, 288-90
- Psychotic character-traits, 216, 218
- Psychotic reactions, 75
- Punishment: delinquents' reactions to, 5, 6, 83, 120, 278; melancholia and, 10; desire for, and delinquency, 22, 80, 82, 83, 85, 278
- Putnam, J. J., 184, 206
- Pyknic type, 158, 159
- Pyromania, 86-7, 89
- Quetelet, A., 152, 153, 162
- "Railway spine", 123
- Ramsay, J., 124, 130, 131, 135, 140
- Rape, 43, 180, 183; epilepsy and, 48, 49
- Reaction character-traits, 2, 5-6; and delinquency, 215, 216
- Recidivism, diminution of measures for xxi, 6, 101, 102, 148, 151, 214, 215, 274; treatment of, 289, 293, 294
- Religious delusions, 21, 22
- Remand centres, 205
- Remand Homes, 204, 205, 306
- Report of the Departmental Committee on Sexual Offences against Young Persons (1926), xvi
- Report of the Departmental Committee on Sterilisation (1934), xxii
- Report of the Medical Psychological Association of Great Britain and Ireland, xiii
- Report on the Psychological Treatment of Crime*, 197, 205
- Revenge motive, 81, 82, 83, 85, 86, 109
- Rex v. Donovan, 200-02
- Rex v. Savage, 107
- Robertson, Sir William, 240
- Romilly, Sir Samuel, 141
- Rosanoff, A. J., 157, 162
- Rosanoff, I. A., 157, 162

- Rosenow, C., 235, 236, 239
 Ross, Frank A., 149, 162
 Royal Commission on Care and Control of the Feeble-minded, 1904, 94, 100
 Royal Eastern Counties Institution, Colchester, 96
 Royal Medico-Psychological Association of Great Britain and Ireland, 56-7, 58-60, 63, 71
 Russia, studies of murderers in, 159

 Sadism, 79, 187, 192, 194, 197-202
 Sauer, W., 159, 162
 Savage, John Henry, case of, 61-2
 Schizoid type, 116, 131
 Schizophrenia, 9, 18-39, 90, 91; its four varieties, 20-39; and criminal responsibility, 56, 66, 90, 91; and sexual offences, 188, 193; spontaneous remission in, 295
 Schizophrenic groups, 158; and intelligence tests, 281
 Schizothymic temperament, 150, 158, 159
 Schneider, F. E. E., 148, 162
 Schuler, E. A., 235, 236, 239
 Scotland, plea of insanity in, 59, 60-63, 107-9, 111, 112
 Self-mutilation, 17, 21, 22
 Self-punishment, 80, 89, 278
 Senile mental deterioration, 40
 Senility and sexual offences, 189, 193
 Sexual offences, 177-206, 279, 305; psychoses and, 12, 13, 22, 31, 75; psychopathic constitution and, 113-15; sterilisation and, 160; action of alcohol and, 165, 167, 171, 172, 173; classification of, 180-81; statistical findings, 180-84, 275; psychological factors in, 184-7; psychiatric factors in, 187-90; senility and, 189, 193; psychological treatment of, 203-6, 272, 288-9; in juveniles, 211; birth-order and, 233; diagnosis of, 278, 279, 284
 Sexual offender, record of, xvi
 Sexual perversion, 6, 18, 84, 180, 186-7, 278
 "Shell shock", 124, 134
 "Shock", and nervous disorders, 124
 Shoplifting, 117-18, 200, 272, 275
 Shrubsall, Dr., 95 *n.*
 Sidgwick, Henry, 223
 Simple delinquency, 2, 5
 Simple schizophrenia, 20, 23
 Slawson, J., 153, 236, 237, 239
 "Social Problem Group", xxii
 South Africa, delinquents in, 159
 Speech defects and delinquency, 209
 Spontaneous remission of symptoms, 295
 Spurzheim, J. C., 142
 Standardised Scales of Intelligence, 97
 Stealing, 84, 86, 305; birth-order and, 233, 237; treatment of, 305. *See* Theft
 Steckel, Miss, 231
 Stekel, W., 198, 206
 Stephen, Sir James Fitzjames, 54-55, 56, 179, 207
 Sterilisation, eugenic, 160
 Stone, x
 Stott, Miss M. B., 269 *n.*, 282
 Stringer, x
 Stumpf, Friedrich, 157
 Stupor, states of, 17, 21
 Substitutive compensatory satisfactions through delinquent acts, 83, 84, 85, 86
 Suicide: depression and, 4, 110, 243, 244; melancholia and, 10, 14, 15, 17, 18, 67-8; schizophrenia and, 19, 21, 22; paranoia and, 29; organic psychoses and, 44; psychopathic states and, 109-10; alcohol and, 168, 170; of sexual character, 190; I.S.T.D. figures, 275
 Sutherland, Edwin A., 150
 Sutherland, H. E. G., 231
 Sutherland, J. D., 124, 140
 Sweden, study of murderers in, 159
 Symonds, C. P., 132
 Syphilis and delinquency, 3, 40, 209, 210

 "Temperamentally defective", 99, 100
 Terman, L. M., 230, 239
 Theft, 86, 155, 168; neurosis and, 6; a symptom of general paralysis of the insane, 42, 43, 45, 46, 188; as defence, 84; as compensation, 85; action of alcohol and, 167, 172; sexual associations of, 84, 200, 202; I.S.T.D. statistics, 275; juvenile, 278; diagnosis of, 278, 279
 Thoinot, L., 179, 207
 Thomson, G. H., 231, 239
 Thurstone, L. L., 228, 230, 231, 234, 235, 239
 "Tics", 73
 Toulon, convicts of, 143
 Transvestism, 187, 200, 202-3
 Traumatic neurasthenia, 131
 "Traumatic neuroses", 123, 124, 125
 Traumatic psychosis, 133
 Tredgold, A. F., 95 *n.*
 Trivial delinquency, 2, 4-5

- Tucker, William B., 149, 162
 Twins, criminal, study of, 156-7
- "Unconscious" mental processes, 76-7
 "Uncontrollable impulse" and criminal responsibility, 66-71
 Unsoundness of mind, the term, 50, 51; and criminal responsibility, 68, 69
- Vision, defective, and delinquency, 152, 209
 Vocational guidance officer, 280, 281, 282
 Voltaire, 141
- War, 81; neuroses in, 78, 88, 124; its effects on behaviour, 243, 244-5; and juvenile delinquency, 274
 Wedding day suicides, 22
 Weihofen, xiii
 Weill, B. C., 229, 236, 239
 Wertham, F., 88, 89, 90, 91, 92, 106
- West End Hospital for Nervous Diseases, 269
 Wexberg, E., 232, 239
 Weyssse, Arthur W., 179, 207
 White, W. A., 62
 Wiggins, D. M., 231, 238
 Wilcox, Miss G. M., 269 *n.*
 Willemse, W. A., 159, 162
 Williams, J. H., 95 *n.*
 Wilson, H., 140
 Wilson, Parker, 94
 Wolfe, H. B., 232, 239
 Woodworth questionnaire, 232
 Wordblindness and delinquency, 209
 Workmen's Compensation Act, 122, 129, 137, 138
 Wormwood Scrubs Boys' Prison, 150-53, 155, 157-8
 "Wrong", meaning of, 54, 55, 56, 57, 103
- Yarnell, H. Y., 86, 89, 92
- Zingerle, H., 200, 207

ENGLISH STUDIES IN CRIMINAL SCIENCE

EDITED BY

L. RADZINOWICZ, LL.D.

AND

J. W. C. TURNER, M.A., LL.B.

It has frequently been a source of surprise to foreign students that no school of law in any of our older Universities had an institution devoted to investigating the great social and legal problems created by the law-breaker. What originally led the University of Cambridge to establish within the Faculty of Law a permanent centre devoted to such investigations was the realisation of the fact that although England had taken in recent years a prominent part in penal reform, very little scientific study of crime and of the administration of criminal law had been achieved in this country. It was also hoped that some useful service might be rendered in connection with the problems of post-war reconstruction and subsequent penal developments. Among the work which has been initiated is the publication of the series called *English Studies in Criminal Science*, the aim of which is to stimulate interest in the solution of the problems created by criminality and to promote further research. Details of the five volumes already arranged to appear in this series are given below. Prices and dates of publication will be announced as the volumes appear. Two of the volumes, *Mental Abnormality and Crime* and *Modern Prison System of India* will appear during 1944 and 1945.

VOLUME I

PENAL REFORM IN ENGLAND

ESSAYS BY

CICELY M. CRAVEN, W. A. ELKIN, S. MARGERY FRY, Sir VIVIAN HENDERSON, ALBERT LIECK, Sir JOHN MAXWELL, A. C. L. MORRISON, C. D. RACKHAM, I. H. REEKIE, S. K. RUCK, and J. A. F. WATSON.

Preface by PROFESSOR P. H. WINFIELD, K.C., LL.D., F.B.A.

Second edition, revised and enlarged

The purpose of this book, which has been welcomed as the best general introduction to contemporary English criminal administration, is to give an authoritative and concise summary of the administration of criminal justice in England to-day. It is a work of collaboration by twelve experts under a definite scheme. It explains the legislative trend of the past fifty years, the working of the machinery of justice, the special treatment of juvenile delinquents and the modern methods of educative punishment. The present edition is brought up to date, revised and enlarged, and it will be found invaluable not only to those who administer criminal justice, but also to all those who are concerned with social progress in general.

★

VOLUME II

MENTAL ABNORMALITY AND CRIME

STUDIES BY

Dr. R. N. CRAIG, Dr. W. NORWOOD EAST, Dr. R. D. GILLESPIE, Dr. E. GLOVER, Dr. D. K. HENDERSON, Dr. E. O. LEWIS, Dr. D. R. MACCALMAN, Dr. ANGUS MACNIVEN, Dr. E. MILLER, Dr. J. D. W. PEARCE, Dr. J. R. REES, Dr. G. de M. RUDOLF, and Dr. G. M. SCOTT.

Preface by PROFESSOR P. H. WINFIELD, K.C., LL.D., F.B.A.

The startlingly high percentage of mental cases of various kinds which has been revealed by modern official investigations is exercising the minds of all who are interested in the welfare of the community. This phenomenon is especially disturbing to those concerned with the administration of criminal justice. The Cambridge Department accordingly procured the collaboration of the distinguished authors of these studies with the aim of explaining in concise and plain terms the relation between mental defect and criminal behaviour. This is the first publication of its kind in England and it is hoped that it will not only assist

those who have to decide upon the treatment to be accorded to the mentally affected delinquent, but will also provide much needed information for workers in the social and moral sciences.

★

VOLUME III

MODERN PRISON SYSTEM OF INDIA

BY

LT.-COL. F. A. BARKER, C.I.E., C.B.E., O.St.J., M.A., M.D., B.C., I.M.S. (Rt.), formerly S.M.O. PORT BLAIR AND Inspector-General of Prisons, C.P. and Punjab.

Notes by Sir LOUIS STUART, C.I.E., and A. CAMPBELL, M.A., I.C.S., late Judge, High Court, Lahore.

Foreword by Lord HAILEY, G.C.S.I., G.C.I.E., G.C.M.G., Hon. D.C.L.

Preface by PROFESSOR P. H. WINFIELD, K.C., LL.D., F.B.A.

It is now coming to be realised that political development and social welfare throughout the British Commonwealth of Nations are linked with the establishment and maintenance of a proper standard of criminal justice. This book describes the main reforms introduced in India since the appearance of the 1919-1920 Report of the "East Indian Jail Committee". Its purpose is to stimulate wider interest in this branch of colonial administration and the author, Colonel Barker, who has taken a prominent part in Indian penal administration for nearly thirty years, is exceptionally qualified to appraise the work so far accomplished. Sir Louis Stuart and Mr. A. Campbell have drawn upon their experience as Indian Judges to add a Note on some peculiar characteristics of criminality in India. This well illustrates the nature of the problems created by local traditions and circumstances.

★

VOLUME IV

THE MODERN APPROACH TO CRIMINAL LAW

STUDIES BY

D. SEABORNE DAVIES, LL.B., R. M. JACKSON, LL.D., the late PROFESSOR C. S. KENNY, L. RADZINOWICZ, LL.D., W. T. STALLYBRASS, D.C.L., J. W. C. TURNER, M.A., LL.B., E. S. C. WADE, LL.D., and B. A. WORTLEY, LL.D.

Preface by PROFESSOR P. H. WINFIELD, K.C., LL.D., F.B.A.

This book, promoted by the Cambridge Department, carries on the tradition initiated some fifty years ago by the late C. S. Kenny, renowned, as Downing Professor of English Law, for his expositions of

criminal law as an academic discipline, and for his far-sighted appreciation of the need for the scientific study of criminality. Jurists of the Universities of Oxford, Cambridge, London and Manchester have collaborated in producing this work on the larger problems of criminal law and its administration at the present day. The volume comprises essays which elucidate major principles of criminal law, indicate the main lines in the development of our penal administration and demonstrate the importance of comparative studies in criminal science. The plan upon which these essays have been chosen and arranged has been constructed so as to emphasize the relation which criminal law bears to the other branches of criminal science.

★

VOLUME V

**AFTER-CONDUCT
OF DISCHARGED OFFENDERS**

BY

SHELDON GLUECK, Ph.D., LL.M., Professor of Criminal Law and Criminology, Harvard Law School, and ELEANOR T. GLUECK, Ed.D., Research Associate in Criminology, Harvard Law School.

Foreword by Dr. FELIX FRANKFURTER, Justice of the Supreme Court of U.S.A.

Preface by PROFESSOR P. H. WINFIELD, K.C., LL.D., F.B.A.

What happens to the former inmates of our prisons and reformatories? How many return to a life of crime and vice? What proportion of them change from aggressive and dangerous criminals to misdemeanants, vagrants, chronic alcoholics and the like? Is imprisonment a preventive of recidivism? To these and similar questions even today we in this country cannot give adequate answers. Some years ago Professor and Mrs. Sheldon Glueck of the Harvard Law School opened a new chapter in criminal science by initiating what are known as "Follow-up Investigations" to obtain the information needed, and the Cambridge Department asked them to make a report on the methods and results of their labours. This book summarises their findings and gives the answers to the questions above stated. The importance of the work which these distinguished authors have promoted is emphasized in the foreword written by Dr. Felix Frankfurter, Judge of the Supreme Court of the U.S.A.

